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IDENTIFIERS	Children of Alcoholics

ABSTRACT

This training program participants' manual is designed to assist K-12 school counselors, nurses, and psychologists in offering aid to youths at risk for substance abuse. The training objectives for participants in the workshop are to be able to demonstrate: (1) competence in knowledge of basic substance abuse information to include age-appropriate signs and symptoms of substance abuse in students; (2) competency at recognizing age-appropriate risk/resiliency factors of students; (3) knowledge of pharmacological effects of substances on students' physical, cognitive, and social/emotional well-being; (4) skill at developing basic prevention activities/programs including but not limited to Student Assistance Programs (SAP); and (5) skill for appropriate counseling and referral techniques for youths at risk of substance abuse. Chapters are: (1) Introductions; (2) Connections between Substance Use and Academics; (3) Signs and Symptoms of Substance Use; (4) Psychopharmacology; (5) Professional Communication Skills; (6) Legal and Ethical Issues; (7) Risk, Resiliency and Protective Factors; (8) Children of Substance Using Parents; (9) Best Practices in Prevention; and (10) Resource Directory (not included). (JBJ)

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ED 387 763

TOOLS FOR PREVENTION: BUILDING HEALTHY YOUTHS

A Training Program for:

- **School Counselors**
- **School Nurses**
- **School Psychologists**

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A Project of the
U. S. Department of Education Drug-Free Schools
and
Communities Program
and

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Co-Sponsored by the
Alabama State Department of Education

CG026571

(Participant Manual)

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10	Resource Directory

May 29, 1995

Dear Educational Professional:

We here at the University of Alabama at Birmingham (UAB) are very excited about this opportunity to work with you in such a meaningful way. We hope this training session will be the beginning of a type of networking among professionals that is much needed across the state of Alabama. Each of you is in a very unique position to offer aid and assistance to youths at risk for substance abuse, and we hope this training program, together with the materials provided to you, will add to your already large storehouse of information and knowledge.

This project is offered to you as a result of a United States Department of Education federal grant that was awarded to the School of Education at UAB in concert with the UAB School of Public Health. This program is co-sponsored by the Alabama State Department of Education, and they too have played a pivotal role in bringing this program to fruition. We here at UAB have designed this training workshop to meet your needs in working on the "firing line" with other school professionals, parents, and the community.

We welcome you to this training program and hope that your expectations for this program will be realized. Further, we hope that this will be the beginning of a long-standing professional relationship with you such that all of us can be resources for each other. Please feel free to call on us for assistance at any time. My telephone number is 205-934-3701, and Mr. Charles Collins' telephone number is 205-975-8387.

Sincerely,

Maxie P. Kohler, Ph.D.
Project Director

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TRAINING AGENDA

Day One

8:00 until 8:30	Registration
	Unit One: Introductions
8:30 until 9:00	Introductions
9:00 until 9:15	Find Someone Who
	Unit Two: Connections Between Substance Use and Academics
9:15 until 9:45	What are the Connections?
9:45 until 10:00	Why Be Concerned?
10:00 until 10:15	Break
	Unit Three: Signs and Symptoms of Substance Use
10:15 until 10:45	Signs and Symptoms
10:45 until 11:15	High-Risk Youths
	Unit Four: Psychopharmacology
11:15 until 11:30	Two Key Concepts
11:30 until 12:30	Psychopharmacology Part One
12:30 until 1:30	Lunch
1:30 until 2:30	Psychopharmacology Part Two
2:30 until 2:45	Break

	Unit Five: Professional Communication Skills
2:45 until 3:00	Peer Pressure Exercise
3:00 until 3:30	Communication Skills Review
	Behavioral Signals
	The Askable Environment
	Keys Skills for Counseling
	Unit Six: Legal and Ethical Issue
3:30 until 5:00	Legal and Ethical Issues
Day Two	
8:00 until 8:15	Review/Preview
	Unit 7: Risk, Resiliency and Protective Factors
8:15 until 8:30	A Developmental Approach to Prevention
8:30 until 9:15	The Puzzle of Risk The Puzzle of Resiliency
9:15 until 10:00	Protective Factors in the Family, School, and Community
10:00 until 10:15	Break
	Unit 8: Children of Substance Using Parents
10:15 until 11:00	The Children of Alcoholics and Addicts
11:00 until 11:30	Identification of COA in the Classroom
11:30 until 12:00	An Integrative Exercise
12:00 until 1:00	Lunch

Unit 9: Best Practices in Prevention

1:00 until 1:30	The Prevention Pyramid
1:30 until 4:30	Best Practices in Prevention Programs: Building a Student Assistance Program Developing a Peer Helper Program Classroom Based Prevention The Community Network Public Policy and Prevention
4:30 until 4:45	Partnership in Prevention/Action Planning
4:45 until 5:00	Closing Activity

TOOLS FOR PREVENTION:
BUILDING HEALTHY YOUTHS

OBJECTIVES OF TRAINING

For students K - 12, each participant will be able to:

1. **Demonstrate competence in knowledge of basic substance abuse information to include age-appropriate signs and symptoms of substance abuse in students;**

2. **Demonstrate competency at recognizing age-appropriate risk/resiliency factors of students;**

3. **Demonstrate knowledge of pharmacological effects of substances on students' physical, cognitive, and social/emotional well-being;**

4. **Demonstrate skill at developing basic prevention activities/programs including but not limited to Student Assistance Programs (SAP);**

5. **Demonstrate skill for appropriate counseling and referral techniques for youths at risk for substance abuse.**

FIND SOMEONE WHO

Please take this list out of your training manual and join the other participants in finding someone in the group who has done one of the listed activities. Once you have found the person, get them to write their name and phone number on your list.

1. Find someone who has started a Student Assistance Program at his/her school.

Name _____

Phone Number _____

2. Find someone who belongs to a Drug Prevention Coalition in his/her community.

Name _____

Phone Number _____

3. Find someone who has taken part in an Anti-Smoking Activity at his/her school.

Name _____

Phone Number _____

4. Find someone who has referred a teenager to a substance abuse treatment program.

Name _____

Phone Number _____

5. Find someone who has brought speakers to the school to address drug and alcohol problems.

Name _____

Phone Number _____

6. Find someone who has taken part in an alcohol-free high school prom.

Name _____

Phone Number _____

7. Find someone who has experience in counseling the children of alcoholics.

Name _____

Phone Number _____

8. Find someone who has conducted an inservice training at his/her school on a drug or alcohol topic.

Name _____

Phone Number _____

9. Find someone who has developed a drug or alcohol prevention program aimed at African American youth.

Name _____

Phone Number _____

10. Find someone who has ordered a publication from the Center for Substance Abuse Prevention.

Name _____

Phone Number _____

11. Find someone who has helped youths develop drug prevention posters, videos, articles for a school newspaper, or rap contests.

Name _____

Phone Number _____

12. Find someone who has developed an alternative activity program for youth as a drug prevention approach.

Name _____

Phone Number _____

WHAT ARE THE CONNECTIONS BETWEEN SUBSTANCE USE AND EDUCATION?

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Why Must the School Counselor, the School Nurse, and the School Psychologist be Involved in Drug and Alcohol Prevention?

I. WHO IS AT HIGH RISK?

II. WHY DO MANY YOUTHS BECOME INVOLVED IN DRUGS AND CRIME?

III. WHY DO MANY YOUTHS EXPERIMENT WITH ILLICIT DRUGS?

IV. WHAT ARE THE MARIJUANA USE PATTERNS FOR YOUTH?

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V. WHAT ARE THE COCAINE USE PATTERNS FOR YOUTHS?

VI. WHAT ARE THE INHALANT USE PATTERNS FOR YOUTHS?

VII. WHAT ARE THE HALLUCINOGENS USE PATTERNS FOR YOUTHS?

VIII. WHAT ARE THE PSYCHOTHERAPEUTICS USE PATTERNS FOR YOUTHS?

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IX. WHAT ARE THE STIMULANTS USE PATTERNS FOR YOUTHS?

X. WHAT ARE THE ALCOHOL USE PATTERNS FOR YOUTHS?

XI. IS SUBSTANCE ABUSE PREVENTION EFFECTIVE?

Why Must the School Counselor, the School Nurse, and the School Psychologist be Involved in Drug and Alcohol Prevention?

I. WHO IS AT HIGH RISK?

* Adolescent drug problems appear to be embedded in a history of family conflict, school failure, and antisocial behavior.

Source: Hawkins, J.D.; Lishner, D.M.; Catalano, R.F. Jr.; and Howard, M.O. Childhood predictors of adolescent substance abuse: Toward an empirically grounded theory. In: Esekoye, S.; Kumpfer, K.; and Bukowski, W. eds. Childhood and Chemical Abuse: Prevention and Intervention, New York; Hawthorn Press, 1986.

* Some of the behaviors correlated with early alcohol and drug use include failing in school, unwanted pregnancy, and delinquency. One fourth of America's 28 million children are at high risk of multiple behavior problems. Seven million youth (about 25%) are at risk because they are starting to use the three gateway drugs of cigarettes, alcohol, and marijuana.

Source: Dryfoos, J.G. "Youth at Risk: One in Four in Jeopardy". Report submitted to the Carnegie Corporation, June 1987.

* Research shows that substance abuse crosses all income levels, educational backgrounds, and racial/ethnic backgrounds. No one group is "immune".

Source: Vincent, L., Poulsen, M., Cole, C., Woodruff, G., and Griffith, D., (1991). Born Substance Exposed, Educationally Vulnerable. Reston, Virginia: Council for Exceptional Children.

* Children of alcoholic parents at all socioeconomic levels are especially vulnerable to chemical dependency.

Source: Cloninger, C.R.; Sigvardsson, S.; Reich, T.; and Bohman, M. Inheritance of risk to develop alcoholism. In: National Institute on Drug Abuse. Genetic and Biological Markers in Drug Abuse and Alcoholism. NIDA Research Monograph Series Nol 66. DHHS Pub. No. (ADM) 86-01444. Washington, DC: Supt. of Docs., U.S. Govt. Print Off., 1986. pp. 86-96.

* While early drug experimentation does not inevitably lead to multidrug abuse, those individuals who use more drugs, more often, at younger ages, than their classmates are also more likely to have multiple drug and alcohol-abuse problems later on.

Source: Newcomb, Michael, D., and Butler, Peter, M. Antecedents and Consequences of Cocaine Use: An eight-year study from early adolescence to young adulthood: In Lee N. Robbins and Michael Rutter (Eds.), Straight and devious pathways from childhood for adulthood. Cambridge, England: Cambridge University Press, 1990.

* Studies show that children who by age 10 have learning difficulties in school, especially in reading, and significant stress at home (such as a single parent, a large family, or low income) are more likely to become delinquent. This is especially true if, as early as age 6, they have signs of attention-deficit disorder and antisocial behavior.

Source: Moffit, E, E, (1990) Juvenile deliquency and attention deficit disorder: Boys' developmental trajectories from age 3 to age 15. Child Developmnet, 61, 893-910.

Source: Wilson, James O. and Herrnstein, Richard J. (1985). Crime and human nature, New York: Simon and Schuster.

* An estimated 5 to 10 percent of all school-aged children are unpopular and friendless.

Source: Asher, Steven R. and Renshaw, Peter D. (1981). Children without friends: Social Knowledge and social skill training. In Steven R. Asher and John M. Gettman (Eds.), The development of children's friendships. Cambridge, England: Cambridge University Press.

* Rejected children are actively disliked by others, often because of their aggressive, disruptive behavior. Many of these children are lonely, unhappy, and have low self-esteem, which affects their learning in school and happiness at home. These children are also more likely than the average child to suffer adjustment problems in adolescence and adulthood.

Source: Parker, Jeffrey G. and Asher, Steven R. (1987) Peer relations and later personal adjustment: Are low-accepted children at risk? Psychological Bulletin, 102, 357-389.

* Improving academic skills in rejected children appears likely to improve self-esteem as well.

Source: Berger, Kathleen (1994). The developing person thrugh the life span. New York: Worth Publishers.

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Source: Coie, John D. and Krehbiel,Gina. (1984). Effects of academic tutoring on the social status of low-achieving socially-rejected children. Child Development, 55, 1465-1478.

Source: Rabiner, David and Coie, John (1989). Effects of expectancy inductions on rejected children's acceptance by unfamiliar peers. Developmental Psychology, 25, 450-457.

* While all adolescents have some difficulties, those with one serious problem seem to have several others as well. For instance, girls who become teenage mothers also tend to be those from troubled families, likely to leave school and experiment with hard drugs before the age of 16. Similarly, boys who become repeat delinquents also tend to be alienated from their families, failing in school, drug-abusing, and lacking in close friends.

Source: Dryfoos Joy G. (1990). Adolescents at risk: Prevalence and prevention. New York: Oxford University Press.

II. MANY YOUTHS BECOME INVOLVED IN THE DRUGS AND CRIME CONNECTION

* The juvenile violent crime arrest rate rose 79% from 1985 to 1991.

* The violent death rate for teens in Alabama rose 25% from 1985 to 1991. Alabama ranked 7th in the United States for violent deaths of teenagers.

Source: Kids Count Data Book:1994, The Annie E. Casey Foundation.

III. MANY YOUTHS HAVE EXPERIMENTED WITH ILLICIT DRUGS

* 20.1% of all 12 to 17 year olds in the United States have used an illicit drug at one time or another. Contrary to popular belief the rate for Black youths (20.4%) is approximately the same as for White youths (20.6%).

Source: National Household Survey on Drug Abuse: November 20, 1992, National Institute on Drug Abuse, U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration.

IV. MARIJUANA USE PATTERNS

* Marijuana is a popular drug with America's youth. 13% of all 12 to 17 year olds have used marijuana. Use in the past month is reported by 4.3% of these youths. Use by Black teens (13.7%) is slightly more than among White teens (13.2%) but this difference is not statistically different.

  Source: National Household Survey on Drug Abuse: November 20, 1992, National Institute on Drug Abuse, U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration.

* The 1994 Monitoring the Future Survey found that marijuana use is up among 8th, 10th, and 12th graders, and anti-drug attitudes are deteriorating. Specifically, over the past two or three years marijuana use has doubled among 8th graders (to 13%), grown by two-thirds among 10th graders (to 25 percent), and grown by 40 percent among 12th graders (to 31 percent).

  Source: The "Monitoring the Future Study" was conducted by scientists at the University of Michigan Institute for Social Research for the Department of Health and Human Services and released on December 8, 1994. Funding for the study was provided by the National Institute on Drug Abuse. To obtain a copy of the study, call (808) 729-6686.

V. COCAINE USE PATTERNS

* Cocaine has been used by 2.4% of youths between 12 and 17 years of age. Crack cocaine has been used by 1.1% of African American youths and .8% of White youths.

  Source: National Household Survey on Drug Abuse: November 20, 1992, National Institute on Drug Abuse, U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration.

VI. INHALANT USE PATTERNS

* Inhalants, such as gasoline, have been abused by 7% of America's youth. More White teens (7.6%) are involved than African American teens (5.1%). Gasoline inhalation appears to be as widespread in rural communities as it is in urban communities.

  Source: National Household Survey on Drug Abuse: November 20, 1992, National Institute on Drug Abuse, U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration.

VII. HALLUCINOGENS USE PATTERNS

* Hallucinogens, such as LSD, have been used by 3.3% of America's youth between 12 and 17 years of age. This drug is seen three times more often among White teens (3.8%) than it is seen in African American teens (1.2%)

Source: National Household Survey on Drug Abuse: November 20, 1992, National Institute on Drug Abuse, U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration.

VIII. PSYCHOTHERAPEUTICS USE PATTERNS

* Psychotherapeutics, such as pain pills, sedatives and tranquilizers, have been abused by 16.4% of America's youth. White teens (18.3%) have abused more of these medicines than have African American teens (12.0%).

Source: National Household Survey on Drug Abuse: November 20, 1992, National Institute on Drug Abuse, U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration.

IX. STIMULANTS USE PATTERNS

* Stimulants, usually called diet pills or speed, have been abused by 3% of America's youth. Use among White teens (3.5%) is over three times greater than among African American teens (.8%). Southern teenagers abuse these type of drugs more than teens in other parts of the country.

Source: National Household Survey on Drug Abuse: November 20, 1992, National Institute on Drug Abuse, U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration.

X. ALCOHOL USE PATTERNS

* Alcohol has been used by 46.4% of America's 12 to 17 years olds. In fact, 20.3% of these youths have used alcohol in the last 30 days. White youths (48.2%) report using more than African American youths (40.7%).

Source: National Household Survey on Drug Abuse: November 20, 1992, National Institute on Drug Abuse, U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration.

* A December 1994 study by the Harvard School of Public Health found that nearly half (44%) of all college students are binge drinkers, consuming five or more drinks at a time. On a national scale, this means that approximately 3 million students a year binge drink, and 1.3 billion do so more than once a week. Fifty percent of binge drinkers in this study said they had ridden with a driver who was high or drunk, and 40 percent of the males said they had driven after five or more drinks. Binge drinking affects not only the drinker but also his or her peers -- physical assault, sexual harassment and impaired sleep and study time are some of the "secondhand binge" effects experienced by non-binging students as the result of the heavy drinking of their classmates.

Source: Study of the "Second-hand Effects of Binge Drinking" conducted by researchers at the Harvard School of Public Health and published in the December 7, 1994 issue of The Journal of the American Medical Association. Funding for the study was provided by The Robert Wood Johnson Foundation. A copy of the study may be obtained by calling (617) 432-1135.

XI. SUBSTANCE ABUSE PREVENTION IS EFFECTIVE

* Substance abuse prevention programs can effectively reverse the serious trend of increased alcohol and drug use by 8th, 10th and 12th graders, which is linked to juvenile crime. A 1994 Cornell University study of 6,000 students found that the odds of drinking or using marijuana were 40% lower among kids who participated in a prevention program during 7th, 8th, and 9th grades than those who did not.

Source: Legal Action Center, 236 Massachusetts Ave. N.E. #505, Washington, D. C. 20002

* The number of adolescents (ages 12 to 17) who drink alcohol has decreased by almost 3 million since 1979 from 37 percent to 20 percent.

Source: Center for Substance Abuse Prevention, from the Executive summary of: A Discussion Paper on Preventing Alcohol, Tobacco, and Other Drug Problems, 1993.

* There has also been a significant decrease in illicit drug use among adolescents -- from 18 percent in 1979 to less than 7 percent in 1991. This represents 2.5 million young people who have stayed away from drugs.

Source: Center for Substance Abuse Prevention from the Executive Summary of: A Discussion Paper on Preventing Alcohol, Tobacco, and Other Drug Problems, 1993.

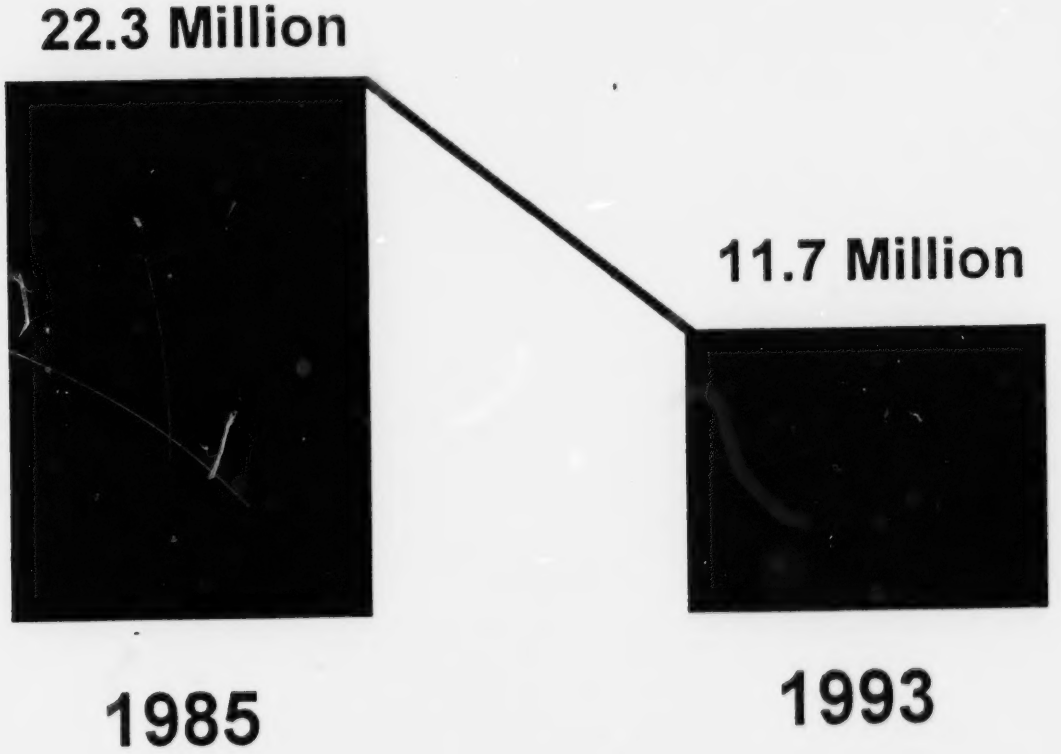
* Prevention messages about the dangers of drinking and driving have reached young people. In fact, the number of fatal alcohol - related car crashes among teens has declined by 55 percent over the past 10 years. However, such crashers among teens has declined by 55 percent over the past 10 years. However, such crashers among young adults aged 21 - 35 have only fallen by 32 percent, indicating the need for more targeted efforts.

Source: National Highway Traffic Safety Administration, 1994.

* A 1994 study by Cornell University Researchers of 6,000 students in New York state found that the odds of drinking, smoking or using marijuana were 40 percent lower among kids who participated in a prevention program during 7th, 8th, and 9th grades than their counterparts who did not.

Source: Study by researchers at the Institute of Prevention Research at Cornell University Medical School released in the summer of 1994. Funding for the study came from the National Institute on Drug Abuse. The study took six years to complete and nearly 6,000 students from 56 schools in New York state were surveyed. For more information about the study, call (212) 746-1270 (The final report is not yet published).

Good News :
Any Drug Use in the Past Month
Down 48%



Source: SAMHSA Household Survey

More Good News:

Treatment Works

$1 invested in drug treatment equals
$7 savings in crime, social services and healthcare.

Source: 1993 California Dept. of Alcohol & Drug Programs

USE VERSUS ABUSE

The National Center for Substance Abuse Prevention now says for children and youths, any substance use is considered substance abuse. Why is this the case?

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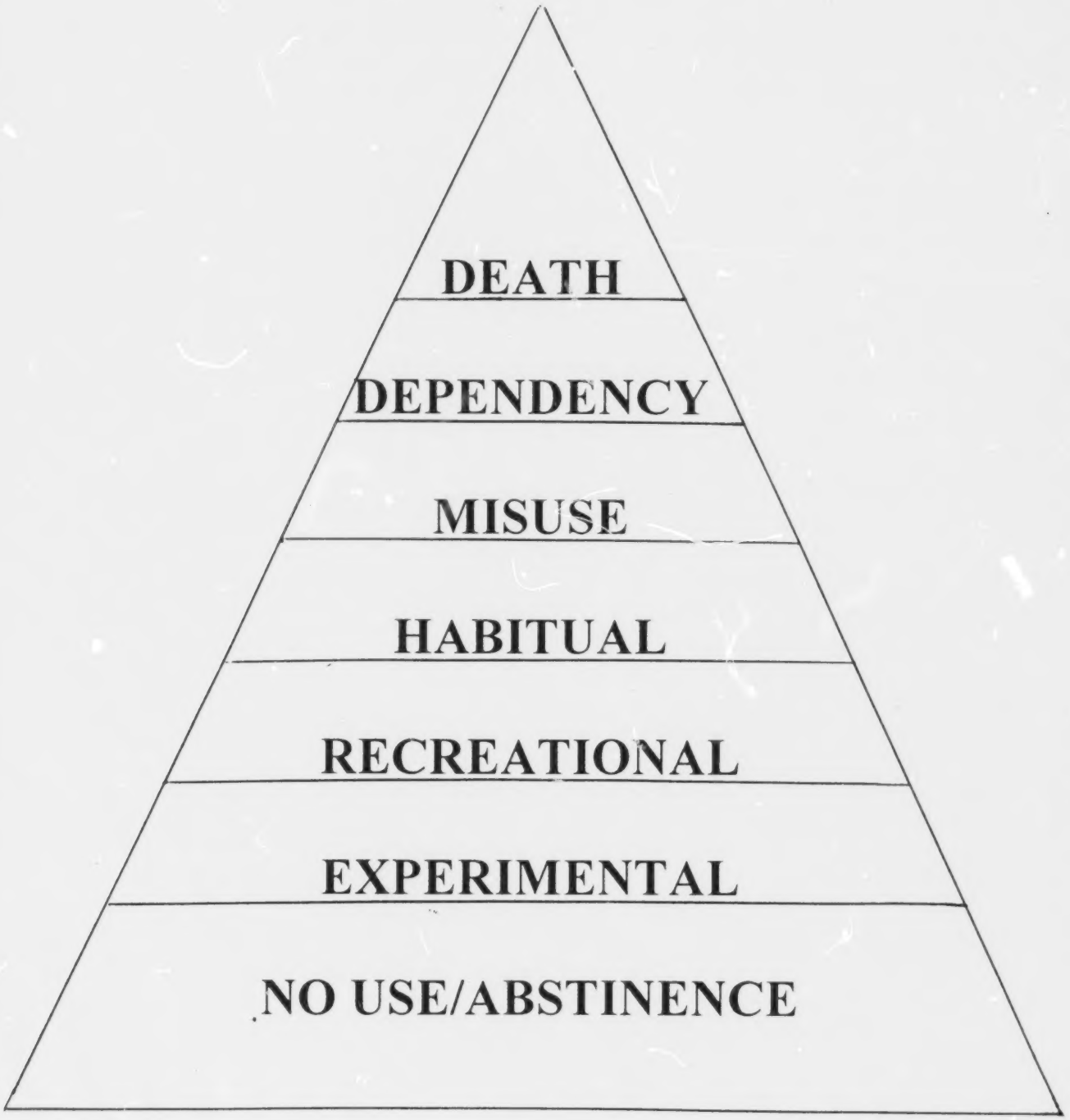
addendum

SUBSTANCE USE BY CHILDREN AND YOUTHS IS CONSIDERED TO BE SUBSTANCE ABUSE BECAUSE:

- Use by children and youths is illegal.
- Their smaller body size means that small amounts of drugs and alcohol impact them more than the same amounts would impact adults.
- Children and youths are cognitively immature.
- Children and youths are emotionally immature.
- Children and youths may not be able to differentiate between prescription medications and illicit substances.
- Drugs and alcohol interfere with the physical maturation process.

addendum

THE SUBSTANCE USE PYRAMID



WHAT ARE SOME PHYSICAL SIGNS AND SYMPTOMS OF SUBSTANCE USE?

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WHAT ARE SOME BEHAVIORAL SIGNS AND SYMPTOMS OF SUBSTANCE USE?

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WHAT ARE SOME EMOTIONAL SIGNS AND SYMPTOMS OF SUBSTANCE USE?

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WHAT ARE SOME SOCIAL SIGNS AND SYMPTOMS OF SUBSTANCE USE?

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WHAT ARE SOME COGNITIVE SIGNS AND SYMPTOMS OF SUBSTANCE USE?

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SIGNS AND SYMPTOMS OF CHEMICAL DEPENDENCY

In Adolescents:

1) Drop in grades
2) Violates value system
3) Loss of motivation
4) Drops out of extra-curricular activities
5) Using before or during school
6) Increased isolation from family
7) Stealing money, alcohol, possessions
8) Physical deterioration
9) Severe personality change
10) Secrecy
11) Defiance of family and school rules

In Adults:

1) Changes in work habits
2) Erratic mood swings
3) Confused thinking
4) Occasional or partial memory lapse
5) Hiding or sneaking chemicals
6) Increased stubbornness and rigidity
7) Denial of problems
8) Breaks promises
9) Blames others for problems
10) Increased tolerance to the drug
11) Family members feel loss of control
12) Makes excuses for using

Source: Belinda Biscoe, Ph.D., The Winner's Circle: Drug Free Schools and Communities, Oklahoma State Department of Education, 1994.

COMMON SYMPTOMATIC CHARACTERISTICS OF CHEMICAL DEPENDENCY IN ADOLESCENTS

Physical Status:

- changes in facial color and degrees of alertness from day to day
- changes in levels of activity from day to day (i.e., alert and active one day, tired and subdued the next)
- change in hygiene - becoming more sloppy, wearing same clothes, etc.
- weight changes - drastic loss or gain
- erratic sleeping patterns - sleeping often/insomnia, extreme difficulty in getting up in the morning
- redness and/or puffiness of eyes, noticeable change in pupils
- persistent cough/runny nose
- changes in coordination/motor skills

Attitude/Emotions:

- low motivation and loss of interest
- often hostile when criticized
- argumentative
- extreme negativism
- stereotyped thinking
- denial of any problem
- low self-esteem
- remorse - with promises to change
- defiance of rules and regulations - pushing limits
- secretive
- emotional highs/lows
- verbally or physically abusive

School:

- chronic tardiness
- excessive absences
- leaving class early
- lower grades - lower achievement

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COMMON SYMPTOMATIC CHARACTERISTICS OF CHEMICAL DEPENDENCY IN ADOLESCENTS (cont'd)

Contact with Others:

- avoidance of contact with concerned persons
- spends less time at home (time at home is often alone, in room)
- makes appointments but does not show up
- avoids talking about or minimizes chemical use with adults but brags with peers
- switching friends
- withdrawing from family functions

Chemical Use:

- frequent use and intoxication
- hiding chemicals
- finding different way(s) to use
- using chemicals in the morning and/or at school or work

Source: The Winner's Circle: Drug Free Schools and Communities, Oklahoma State Department of Education, 1994.

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High-Risk Youths

Youths who experience multiple risk factors are considered to be at high risk for alcohol, Tobacco, and Other Drugs. The U. S. Department of Education definition of high-risk youth is a youth under the age of 21 who:

are children of substance abusers;

are victims of physical, sexual, or psychological abuse;

have experienced chronic failure in school;

have dropped out of school;

have become pregnant;

are economically disadvantaged;

have committed a violent or delinquent act;

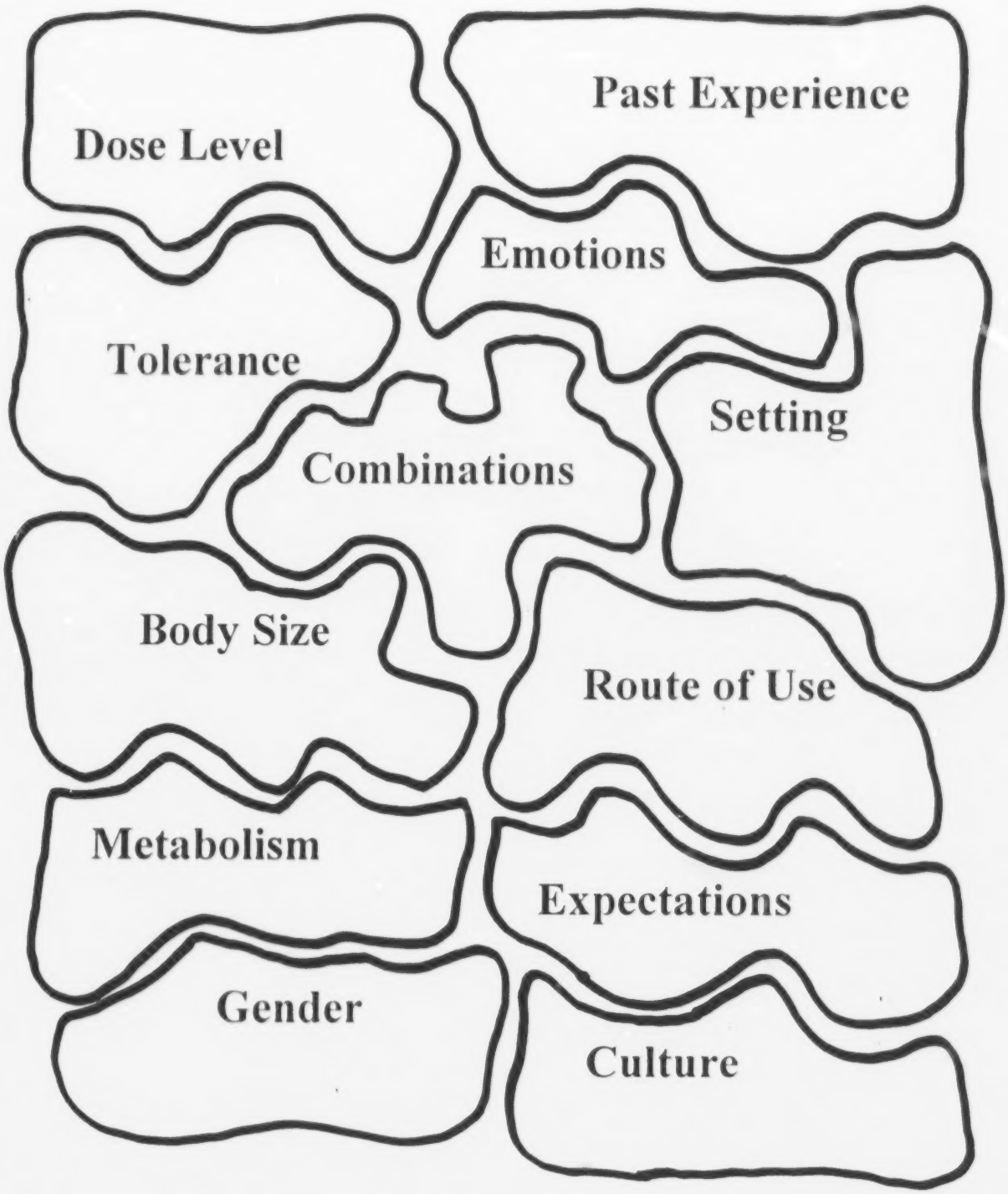
have experienced mental health problems;

have attempted suicide; and

have experienced long-term physical pain due to injury.

highrisk

FACTORS THAT INFLUENCE THE ACTION OF ANY SUBSTANCE OF ABUSE



FACTORS THAT INFLUENCE THE ACTION OF ANY SUBSTANCE OF ABUSE
(Reference)

DOSE LEVEL: With all drugs, the amount ingested influences the action of the drug.

TOLERANCE: Tolerance is the process whereby it requires more and more of a substance to achieve the same "high". This is due to tissue tolerance whereby the body becomes accustomed to a particular dose level and thus requires ever larger doses. However, psychological tolerance has also been noted. This means that the user loses the fear of overdose and increases his/her dose beyond the typical dose used to get high.

SETTING: Some settings, such as nightclubs, parties, informal social events may set the stage for drugs to have a greater effect than when the same dosage is used by a person before appearing in court. It is possible for many intoxicated persons to act sober in an emergency such as being stopped by the police.

COMBINATION WITH OTHER DRUGS: The range of possible combinations of drugs and alcohol influence their actions.

BODY SIZE: In general, larger persons can use more drugs and alcohol than can smaller persons. There are drugs such as alcohol where this is especially true. There are drugs such as LSD however where body size makes little difference in the level of intoxication.

GENDER: Women are usually smaller than men and also have a slower metabolism rate. Therefore, less drugs and alcohol are required to intoxicate a woman than a man.

PAST EXPERIENCES WITH THE SUBSTANCE: Past experience influences route of use, amount of use, and selection of setting to use the drug. In addition past experience may increase anxiety or lessen anxiety depending on whether or not the past experiences are judged to be bad or good by the user.

EXPECTATIONS OF THE USER: Expectations are one of the strongest factors impacting the action of a drug. The same drug may cause hypersexuality in one person and impotence in another. The same drug may cause paranoia in one person and relaxation and well being in another.

reffacto

CULTURAL FRAMEWORK: Cultures direct some drug use and alcohol use for people. Alcohol used at a football game may evoke different behaviors from the same amount of alcohol used at an office party. Hallucinogens may be a part of some religious ceremonies for Native Americans, whereas these same chemicals may be used by other with no spiritual goals or connections when using.

EMOTIONAL STATE: Emotional state, like expectations, are strong predictors of the effects of a drug. In general, drugs change emotional states for many people. In fact, that is why the drug or alcohol is used. A person with high anxiety may smoke marijuana or drink alcohol to relax and not remain anxious about a pressing situation. However, this strategy can backfire when emotions can not be repressed and in an intoxicated state the user is unable to manage their emotions.

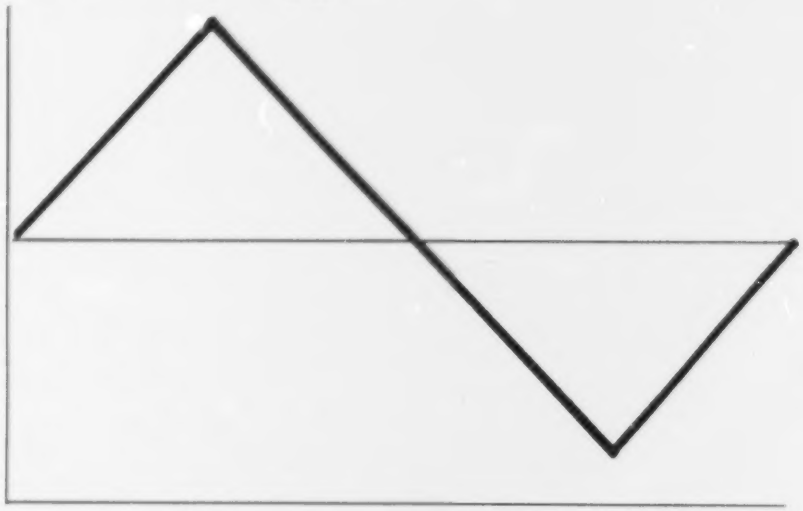
INDIVIDUAL METABOLISM: Even though men in general have increased metabolism when compared to women, there are wide individual differences that impact how long a drug or alcohol may remain in the body.

ROUTE OF USE: Smoking any drug is the fastest route to the brain. This is followed by injection into the veins. Oral ingestion is slower than smoking or injecting.

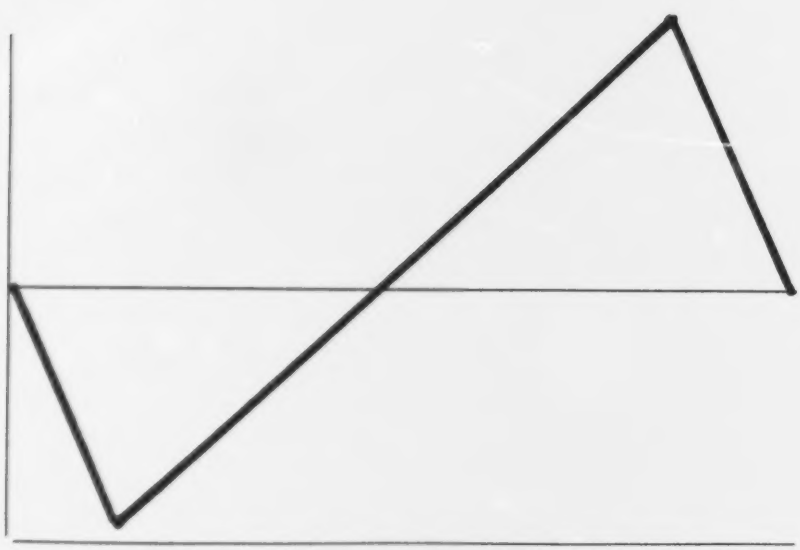
reffacto

Homeostasis and Drug Use

Pattern for "Uppers"



Pattern for "Downers"



ALCOHOL WORKSHEET

CLASSIFICATION:

ROUTES OF USE:

MIXING PATTERNS WITH OTHER DRUGS:

ACTION ON THE EMOTIONS:

ACTION ON COGNITION:

ACTION ON BEHAVIOR:

ACTION ON SENSATION:

DOSE LEVEL CONSIDERATIONS:

OVERDOSE POTENTIAL:

TOLERANCE:

WITHDRAWAL:

POTENTIAL FOR CHEMICAL DEPENDENCY:

OTHER CONSIDERATIONS:

ALCOHOL REFERENCE

CLASSIFICATION: Alcohol is a depressant. Many people find this hard to believe and relate how alcohol makes them act out. There is an explanation for alcohol's actions. Alcohol acts to depresses behavioral inhibitors, allowing behaviors that we naturally censor to emerge. This is why alcohol is also said to disinhibit.

ROUTES OF USE: Oral ingestion is the primary route of use.

MIXING PATTERNS WITH OTHER DRUGS: Alcohol is frequently mixed with marijuana because these are the two most commonly used drugs. Alcohol is mixed with stimulants and cocaine to help relieve the anxiety and nervousness brought about by these drugs. Alcohol may be mixed with opiates or tranquilizers but this is less common since the combination of these drugs brings about sleep.

ACTION ON THE EMOTIONS: Because alcohol is a disinhibitor, a range of controlled or suppressed emotions will emerge when alcohol is used. Grandiose braggart behavior may emerge as a person attempts to impress listeners. Aggressive violent behavior may emerge in a person who had suppressed these feelings in everyday interactions. Sexually seductive behavior may emerge in a person. Crying depressed behavior may emerge in a person who copes with life's disappointments well until intoxicated.

ACTION ON COGNITION: Increased dosages dramatically effect cognition with loss of memory and inability to properly process information. In effect, as the dose increases the brain begins to go to sleep.

ACTION ON BEHAVIOR: Alcohol's disinhibiting effects act on behavior in the same way they act on emotions. Criminal behavior, assault, rape, battery, etc. all increase in persons who are intoxicated.

ACTION ON SENSATION: Increased dosages decrease all sensation such as taste, hearing, and temperature sensation. Masters and Johnson documented that less blood flows to the genital area when intoxicated and thus even sexual sensation is decreased. Paradoxically, people report they become more sexually aroused when using alcohol. This is due to alcohol's disinhibition effects rather than its effects on sensation.

DOSE LEVEL CONSIDERATIONS: Alcohol impacts people depending on body weight, gender, tolerance, and the time between doses. Alcohol is gradually metabolized by the body so a person who sips on a drink over several hours may feel absolutely no impact from the alcohol. In general men metabolize alcohol faster than women. Heavier persons can use more alcohol with less effects.

OVERDOSE POTENTIAL: Highest among adolescents who will drink large amounts on a dare from peers. This can result in alcohol poisoning.

TOLERANCE: There is a distinct tolerance pattern with alcohol use. More alcohol is required to achieve the same result.

WITHDRAWAL: Persons who become physically dependent on alcohol will show withdrawal symptoms which includes tremors as the most obvious sign.

POTENTIAL FOR CHEMICAL DEPENDENCY: There is mounting evidence that some persons have a genetic predisposition to become physically dependent on alcohol. However, anyone who consistently drinks alcohol, increases their dose level as tolerance develops and can become physically dependent on alcohol.

OTHER CONSIDERATIONS:

COCAINE WORKSHEET

CLASSIFICATION:

ROUTES OF USE:

MIXING PATTERNS WITH OTHER DRUGS:

ACTION ON THE EMOTIONS:

ACTION ON COGNITION:

ACTION ON BEHAVIOR:

ACTION ON SENSATION:

DOSE LEVEL CONSIDERATIONS:

OVERDOSE POTENTIAL:

TOLERANCE:

WITHDRAWAL:

POTENTIAL FOR CHEMICAL DEPENDENCY:

OTHER CONSIDERATIONS:

COCAINE REFERENCE

CLASSIFICATION: Cocaine's actions are most similar to the stimulant family of drugs. Like other stimulants, they increase heart rate, blood pressure, decrease sleep, decrease hunger, decrease thirst, increase energy, and increase euphoria. Some side effects of both cocaine and stimulants are nervousness, anxiety, and paranoid thoughts. However, unlike other stimulants, cocaine is also an analgesic (pain killer).

ROUTES OF USE: Cocaine can be used in numerous ways. Powered cocaine hydrochloride can be absorbed by any mucous membrane. Therefore it can be absorbed through the nose, the mouth, and even through the mucous membranes of the genitals. Another route of use is through smoking hot cocaine vapors. This can be done either through smoking heated cocaine crystals, called "crack", or through smoking these powered crystals mixed with marijuana, which is called "primo". Another route of use is through injections into muscle tissue, or more commonly into veins.

MIXING PATTERNS WITH OTHER DRUGS: Cocaine is frequently mixed with other drugs for various reasons. Powered cocaine crystals are mixed with marijuana to form primo, which is smoked. Cocaine powder and any of the opiate family can be mixed for an injection, called an eight ball. This is the way that comedian John Belushi died. Cocaine is also used with alcohol and with the benzodiazepines. Cocaine is never mixed with stimulants because the drugs are very similar in action. Cocaine is never knowingly mixed with LSD because the suspicious anxiety created by cocaine mixed with the hallucinatory effects of LSD lead to a "bad trip" in the extreme. Why then is cocaine, an energizing stimulant, mixed with a range of downers such as alcohol, tranquilizers, and opiates? This is because all these "downers" help relieve the anxiety and nervousness created by cocaine. At the same time, the euphoria produced by these drugs acts synergistically with the cocaine to increase and/or prolong the sense of euphoria.

ACTION ON THE EMOTIONS: Cocaine makes people euphoric and optimistic at low doses. However, at higher doses paranoid thinking emerges and the cocaine user may become very fearful and emotionally volatile. As dose level increases, so does a sense of paranoia suspicion, and volatile emotions which can lead to violence.

ACTION ON COGNITION: Cocaine at low or moderate doses gives people the impression that their thoughts are brilliant. In conversations, they think they are a genius. They seem to believe that they can talk others into anything. They think they have become super-salesmen. People who use cocaine believe that they are actually thinking much faster than when they are not using cocaine. The immediate impact of cocaine is a sense that one has had a sexual orgasm. As the dose level increases, paranoid thinking patterns emerge. This is usually evidenced by withdrawal while using, isolation from others, and suspicion of others. As the dose level increases even beyond this level, paranoid thinking is heightened by hallucinations. These start as aural hallucinations. Cocaine users will spend hours looking around their homes for the noises they imagine they are hearing. If the dose level goes even higher, visual hallucinations will occur. Again, the content of these visual hallucinations is related to suspicion and guilt.

ACTION ON BEHAVIOR: Cocaine stimulates behaviors that are correlated with the dose level. Small doses stimulate talkative, grandiose behaviors. As the dose increases, behaviors become more secretive, paranoid, and withdrawn. One important difference between cocaine and other drugs is that cocaine impacts the lateral hypothalamus. This is the part of the brain that controls thirst, hunger and our sex drive. Thus when a person uses cocaine, they totally block out any sense of hunger or thirst. Also, it is fairly common for men to report that they get an erection when they use cocaine and women frequently report that cocaine causes the vagina to become lubricated.

ACTION ON SENSATION: Cocaine is an analgesic. Because it is a natural pain killer, people report accidents on cocaine that they do not feel until they have come down from the cocaine high. Crack smokers frequently burn their tongue and lips with superheated cocaine vapors yet do not feel the pain due to cocaine's analgesic properties.

DOSE LEVEL CONSIDERATIONS: Dramatic differences occur with increased dose level of cocaine. Thinking patterns go from quick stimulated thoughts to paranoid ideations. Behavior patterns go from social interaction to withdrawal as dose increases.

OVERDOSE POTENTIAL: Cocaine has a high overdose potential. Blood pressure and pulse rate both are greatly increased with cocaine use. Cardiovascular accidents and cerebral vascular accidents may occur.

TOLERANCE: Cocaine does not have the classic tolerance pattern that alcohol and opiates have where increased doses are required to get the same effect. However, as cocaine users become accustomed to the ever increasing doses, they will push the limit of cocaine that they are using. Many cocaine users push this limit too far and will have a seizure. Continued high doses can lead to cardiovascular accident or cerebral vascular accident.

WITHDRAWAL: When a person uses cocaine and they receive the combined effects of euphoria, increased energy, talkativeness, alertness, lack of hunger, lack of thirst, and optimism. When they come down from the drug, which some refer to as "crashing", they get the opposite effects of depression, listlessness, withdrawal, fatigue, hunger, thirst, and pessimism.

POTENTIAL FOR CHEMICAL DEPENDENCY: Very high because whereas cocaine does not cause tissue dependency like alcohol or opiates, it is probably the strongest drug for stimulating psychological dependency. It is characteristic of cocaine that as soon as blood plasma levels begin to drop, which takes 15 to 45 minutes, severe cocaine cravings start.

OTHER CONSIDERATIONS: Because cocaine stimulates intense craving, young people have been known to trade sex for small amounts of cocaine. The United States in 1993 had the highest rates of syphilis and gonorrhea since World War II. This has been directly linked to the trading sex for cocaine phenomena that has spread throughout the country.

HALLUCINOGENS WORKSHEET

CLASSIFICATION:

ROUTES OF USE:

MIXING PATTERNS WITH OTHER DRUGS:

ACTION ON THE EMOTIONS:

ACTION ON COGNITION:

ACTION ON BEHAVIOR:

ACTION ON SENSATION:

DOSE LEVEL CONSIDERATIONS:

OVERDOSE POTENTIAL:

TOLERANCE:

WITHDRAWAL:

POTENTIAL FOR CHEMICAL DEPENDENCY:

OTHER CONSIDERATIONS:

HALLUCINOGENS REFERENCE

CLASSIFICATION: Hallucinogens include a wide range of substances, both natural and man-made. Some of the natural substances include morning glory seeds, jemison weed, marijuana, peyote, and psilocybin mushrooms. The most common of the man made hallucinogens is LSD.

ROUTES OF USE: Oral ingestion is the primary route of use, however the major hallucinogen in terms of number of users is marijuana which is smoked.

MIXING PATTERNS WITH OTHER DRUGS: Mixing these compounds with other drugs is sometimes done by new users but the mixing of other drugs with hallucinogens increases the chances of a bad trip.

ACTION ON THE EMOTIONS: Because hallucinogens create imaginary images, voices, noises, smells, and tastes for the user, they can stimulate a range of emotions. They are completely unpredictable in this regard. For example, two people may use the same dose of LSD and one becomes euphoric from their conversation with God while another becomes almost suicidal thinking that they can see cancers all over their body.

ACTION ON COGNITION: Cognition is impacted as the brain tries to sort out and make sense of the hallucinations that occur. The brain must actively try to sort out whether visions are real or imaginary. The user tries to hold on to logical processes but what they are experiencing is beyond logic.

ACTION ON BEHAVIOR: The key to understanding behavior under the influence of hallucinogens is that the images and illusions direct much of the behavior. Therefore, behaviors are totally unpredictable and depend for the most part on each individual's illusions.

ACTION ON SENSATION: This is where hallucinogens really do their job. All sensations can become distorted, challenging the user to sort reality from illusion. This can be extremely frightening for some people.

DOSE LEVEL CONSIDERATIONS: Many of the natural hallucinogens become more toxic at higher dose levels. Many cause nausea and vomiting. Unfortunately the vomiting doesn't stop the hallucinations.

OVERDOSE POTENTIAL: This differs from hallucinogen to hallucinogen. Jemison Weed has the highest overdose potential.

TOLERANCE: There is no tolerance build up with hallucinogens.

WITHDRAWAL: Marijuana is the only hallucinogen with the possibility of psychological

withdrawal. There is no tissue dependency with any of the hallucinogens.

POTENTIAL FOR CHEMICAL DEPENDENCY: Low

OTHER CONSIDERATIONS:

MARIJUANA WORKSHEET

CLASSIFICATION:

ROUTES OF USE:

MIXING PATTERNS WITH OTHER DRUGS:

ACTION ON THE EMOTIONS:

ACTION ON COGNITION:

ACTION ON BEHAVIOR:

ACTION ON SENSATION:

DOSE LEVEL CONSIDERATIONS:

OVERDOSE POTENTIAL:

TOLERANCE:

WITHDRAWAL:

POTENTIAL FOR CHEMICAL DEPENDENCY:

OTHER CONSIDERATIONS:

MARIJUANA REFERENCE

CLASSIFICATION: Marijuana is a mild hallucinogen. This places marijuana in the same family as LSD.

ACTION ON THE EMOTIONS: Marijuana may have a range of effects on the emotions of adolescents. For many, the effects are relaxing and euphoric. However, for a few, the changes in perception brought about by marijuana can stimulate anxiety and fear responses.

ACTION ON COGNITION: Marijuana impairs thinking in several ways. First, marijuana impairs sequencing so that tasks involving several sequential steps become very difficult to execute. Adolescents high on marijuana may find it difficult to connect one sentence with the following sentence when reading. Adolescents high on marijuana may forget sequential steps and appear lost in a task that they have previously mastered. Second, marijuana impairs time perception so that thoughts are often slowed. Third, marijuana impairs short-term memory and encoding into long term memory. Adolescents may forget what they are doing mid-task. Fourth, marijuana gives a false sense of insight. Adolescents may have thoughts that appear as brilliant insights when high but which are mundane when sober.

ACTION ON BEHAVIOR: Marijuana causes most individuals to relax and become euphoric. Thus, they do not wish to be extremely active when high. Because of the distortion of time however, some persons who are high on marijuana may take part in some activities such as stringing beads or drawing for long periods of time. Reaction time is slowed when high on marijuana so driving is impaired.

ACTION ON SENSATION: Marijuana has dramatic effects on the senses. Marijuana distorts perceptions and heightens pattern recognition. Therefore music seems to sound completely different when high. Songs appear to last forever and subtle nuances in the music are pick-up. Taste is also distorted with most people reporting that foods taste both different and better. This has lead to the slang term: "the munchies" which describes the refrigerator raiding behavior of a person high on marijuana. Vision is not appreciably distorted like it is with marijuana's cousin LSD.

DOSE LEVEL CONSIDERATIONS: Marijuana's psychopharmacological actions begin with small doses. Dose level most often impacts the length of intoxication more than the severity of intoxication.

OVERDOSE POTENTIAL: Marijuana has very low overdose potential. There is no documentation of death due to marijuana overdose.

OTHER CONSIDERATIONS: Some individuals, estimated to be 10% to 15% of the population, do not react with calm, relaxed euphoria when high on marijuana. For them, the changes in perception and the lack of mental concentration causes feelings of fear and anxiety. These persons also report paranoid feelings.

OPIATE WORKSHEET

CLASSIFICATION:

ROUTES OF USE:

MIXING PATTERNS WITH OTHER DRUGS:

ACTION ON THE EMOTIONS:

ACTION ON COGNITION:

ACTION ON BEHAVIOR:

ACTION ON SENSATION:

DOSE LEVEL CONSIDERATIONS:

OVERDOSE POTENTIAL:

TOLERANCE:

WITHDRAWAL:

POTENTIAL FOR CHEMICAL DEPENDENCY:

OTHER CONSIDERATIONS:

OPIATE REFERENCE

CLASSIFICATION: Opiates are in a class to themselves. Their primary action is as an analgesic (pain killer) however they have considerable psychological impacts. They relax the body and give the user a sense of well being.

ROUTES OF USE: Opiates are for the most part oral medications. They are frequently prescribed by physicians. Percodan, Sublimase, Dilaudid, Tylox, Codeine, Darvon, are all prescription opiates. Substance abusers may chose to shoot the opiates into their veins however, to increase the euphoric feeling of intoxication. Pharmaceuticals or illicit opiates may both be injected. Injected opiates bought on the streets may include heroin. Currently there is a revival of the use of smoked opiates. Heroin can be easily smoked with an immediate euphoric high.

MIXING PATTERNS WITH OTHER DRUGS: Cocaine is the most frequently combined drug with opiates.

ACTION ON THE EMOTIONS: Opiates relax and give a feeling of optimistic, euphoric well being. Violent or aggressive behavior is rarely seen when a person is high on an opiate.

ACTION ON COGNITION: Interestingly, cognition is only somewhat altered with use of opiates. Logical processes, memory, sequencing events, are all unimpaired for the most part. However, the dramatic relaxation caused by opiate use is not conducive to intense concentration. Everyday functioning such as driving, cleaning house, working in repetitive jobs, etc. are not impaired by opiates. However, the preoccupation with trying to obtain the next dose may disrupt the person's personal life or employment status.

ACTION ON BEHAVIOR: Due to the relaxing effects of opiates, persons who use them are somewhat sleepy and may "nod off" if not active. However, if they remain on their feet and remain active, they function very well at tasks.

ACTION ON SENSATION: Since opiates are analgesics, sensations of all types are dulled. Persons who are intoxicated with opiates may not respond as quickly to pain sensations such as cuts or burns as would a person who had no opiates in their system.

DOSE LEVEL CONSIDERATIONS: Increased dosage results in more sleeping behavior.

OVERDOSE POTENTIAL: When opiates are taken in large quantities, the user will fall into a deep sleep. If the dose level is sufficient enough, their breathing becomes more and more shallow. If the dose level is too high, they gradually cease to breathe and die.

TOLERANCE: Tolerance builds extremely quickly with these drugs. Within a week of continual use, dosages must be increased to obtain the same level of intoxication.

WITHDRAWAL: Once tissue dependency is established, additional opiates are required every 4 to 12 hours to stop withdrawal symptoms. Opiate withdrawal causes a person to ache with painful flu like symptoms for several days until the body has completed the withdrawal/detoxification process.

POTENTIAL FOR CHEMICAL DEPENDENCY: Every day millions of Americans use pain pills as prescribed by their physician. For most of these people, it never occurs to them to double the dosages prescribed to seek intoxication. Many Americans through extended use of prescription opiates become iatrogenically addicted and are detoxed with no continued use of opiates. However, for those who purposely misuse analgesics by taking too many when no pain symptoms are present, the potential for eventual chemical dependency is high.

OTHER CONSIDERATIONS: Methadone is an opiate that can be used to get opiate addicts (1) off injection drugs, and (2) away from drug dealers and the criminal element that surrounds illicit drug use. However, methadone is a strong opiate itself and there are considerable problems in detoxing off of methadone and living a completely drug free life.

STIMULANT WORKSHEET

CLASSIFICATION:

ROUTES OF USE:

MIXING PATTERNS WITH OTHER DRUGS:

ACTION ON THE EMOTIONS:

ACTION ON COGNITION:

ACTION ON BEHAVIOR:

ACTION ON SENSATION:

DOSE LEVEL CONSIDERATIONS:

OVERDOSE POTENTIAL:

TOLERANCE:

WITHDRAWAL:

POTENTIAL FOR CHEMICAL DEPENDENCY:

OTHER CONSIDERATIONS:

STIMULANT REFERENCE

CLASSIFICATION: Stimulants are in a family to themselves and are usually called "speed" in the drug-using culture. Stimulants increase heart rate, blood pressure, decrease sleep, decrease hunger, decrease thirst, increase energy, and increase euphoria. Some side effects of stimulants are nervousness, anxiety, and paranoid thoughts.

ROUTES OF USE: Stimulants can be used in numerous ways. The most frequent use is through swallowing pills. Powdered stimulants can be absorbed by any mucous membrane. Another route of use is through injections into muscle tissue, or more commonly into veins.

MIXING PATTERNS WITH OTHER DRUGS: Stimulants may be used with alcohol and with the benzodiazepines in an attempt to "calm down". Stimulants are never mixed with cocaine because the drugs are very similar in action.

ACTION ON THE EMOTIONS: Stimulants make people euphoric and optimistic at low doses. However, at higher doses paranoid thinking emerges and the stimulant user may become very fearful and emotionally volatile. Because as dose level increases, so does a sense of paranoid suspicion, volatile emotions can become violent.

ACTION ON COGNITION: People who use stimulants believe that they are actually thinking much faster. As the dose level increases, paranoid thinking patterns emerge. This is usually evidenced by withdrawal while using. As the dose level increases even beyond this level, paranoid thinking is heightened by hallucinations. These start as aural hallucinations. If the dose level goes even higher, visual hallucinations will occur.

ACTION ON BEHAVIOR: Stimulants impact behaviors in relationship to dose level. Small doses stimulate talkative and energetic behaviors. As the dose increases, behaviors become more secretive, paranoid, and withdrawn. When a person uses stimulants, they totally block out any sense of hunger or thirst.

ACTION ON SENSATION: All senses are heightened with use of stimulants.

DOSE LEVEL CONSIDERATIONS: Differences do occur with increased dose level of stimulants. Thinking patterns go from quick stimulated thoughts to paranoid ideation. Behavior patterns go from energetic social interaction to withdrawal as dose increases.

OVERDOSE POTENTIAL: Stimulants have a high overdose potential. Blood pressure and pulse rate both are greatly increased. Cardiavascular accidents and cerebral vascular accidents may occur.

TOLERANCE: Stimulants do not have the classic tolerance pattern that alcohol and opiates have where increased doses are required to get the same effect. However, as stimulant users grow acustomed to ever increasing doses, they will push the limit.

WITHDRAWAL: When a person uses stimulants and they receive the combined effects of euphoria, increased energy, talkativeness, alterness, lack of hunger, lack of thirst, and optimism. When they come down from the drug, which some refer to as "crashing", they get the opposite effects of depression, listlessness, withdrawal, fatigue, hunger, thirst, and pessimism. Suicidal ideation is common during a crash from stimulant use.

POTENTIAL FOR CHEMICAL DEPENDENCY: Moderate potential for psychological dependency.

OTHER CONSIDERATIONS:

TRANQUILIZER WORKSHEET

CLASSIFICATION:

ROUTES OF USE:

MIXING PATTERNS WITH OTHER DRUGS:

ACTION ON THE EMOTIONS:

ACTION ON COGNITION:

ACTION ON BEHAVIOR:

ACTION ON SENSATION:

DOSE LEVEL CONSIDERATIONS:

OVERDOSE POTENTIAL:

TOLERANCE:

WITHDRAWAL:

POTENTIAL FOR CHEMICAL DEPENDENCY:

OTHER CONSIDERATIONS:

TRANQUILIZER REFERENCE

CLASSIFICATION: There are several types of tranquilizers on the market. By far the most popular and the most abused are the Benzodiazepine family.

ROUTES OF USE: Benzos, such as Valium, Xanex, and Atavan, are usually taken orally.

MIXING PATTERNS WITH OTHER DRUGS: When used with other "downers" such as opiates or alcohol, the tranquilizing effects are increased. There is increased relaxation and sleepiness.

ACTION ON THE EMOTIONS: Emotions are flattened by tranquilizers. All emotions, whether happy or sad, are equally flattened and suppressed.

ACTION ON COGNITION: Learning, memory, and concentration are all impaired by benzo use.

ACTION ON BEHAVIOR: Muscle tone is relaxed and most persons on tranquilizers are inactive and sleepy.

ACTION ON SENSATION: All sensation is dulled with tranquilizer use.

DOSE LEVEL CONSIDERATIONS: As the dose level increases, sleep is induced.

OVERDOSE POTENTIAL: With high doses, a benzo user can sleep for days, becoming dehydrated.

TOLERANCE: Tolerance does occur with tranquilizers so that the user must use either higher doses or take the pills more frequently, or both to obtain the same degree of intoxication and relaxation.

WITHDRAWAL: Benzo withdrawal follows the classic homeostasis model. Tranquilizers make you feel relaxed, unconcerned, unemotional, calm, sleepy, with decreased sensation. Withdrawal makes a person feel anxious, nervous, on edge, tense muscles, emotionally volatile, with all senses turned on high. These symptoms are intense at first and may last one week to ten days. Seizures may occur during this 7 to 10 day period. After the 10th day, the symptoms decrease but may continue for another 20 to 30 days.

POTENTIAL FOR CHEMICAL DEPENDENCY: With continued daily use, tissue dependency does occur.

OTHER CONSIDERATIONS:

INHALANTS WORKSHEET

CLASSIFICATION:

ROUTES OF USE:

MIXING PATTERNS WITH OTHER DRUGS:

ACTION ON THE EMOTIONS:

ACTION ON COGNITION:

ACTION ON BEHAVIOR:

ACTION ON SENSATION:

DOSE LEVEL CONSIDERATIONS:

OVERDOSE POTENTIAL:

TOLERANCE:

WITHDRAWAL:

POTENTIAL FOR CHEMICAL DEPENDENCY:

OTHER CONSIDERATIONS:

INHALANTS REFERENCE

CLASSIFICATION: There is no single classification for inhalants because many chemical compounds can be inhaled. Inhalant actually refers to the method that the drugs or chemical is used rather than as a class. However, because this misuse of chemicals has the method of use as the common factor, they all are grouped under the term "inhalant". Gasoline is the most common inhalant used in the United States today. It is extremely easy for adolescents to obtain gasoline, whether they live in rural or urban settings. Further, there is usually just enough gasoline left in the gas lines at filling stations to get adolescents high, so they don't even need any money. The second most commonly inhaled compound is aerosol gases. These are inhaled by filtering the gases through toilet tissue tubes stuffed with tissue paper. The paper absorbs the deodorant, or cooking spray, or room deodorizer, and allows the gases to pass through. There are two products that initially were greatly misused having been changed by the manufacturer to insure that they can not be abused. One of these is model airplane glue and the other is Liquid Paper. Tolulene was removed from model airplane glue and ether was removed from Liquid Paper.

ROUTES OF USE: Inhaling of fumes can be done several ways. Gasoline is extremely easy to inhale whereas aerosol gases require some method of separating the gases from the can contents. This can be as easy however as spraying the contents down into a garbage can and inhaling the rising fumes. The slang term for a person who inhales fumes is a "hacker".

MIXING PATTERNS WITH OTHER DRUGS: Any inhaled drug can be mixed with any other compounds. Most inhalants give an alcohol-like disorientation.

ACTION ON THE EMOTIONS: Gasoline doesn't impact emotion as much as it impacts cognition, behavior, and sensation.

ACTION ON COGNITION: Gasoline inhalation causes mental confusion, lack of concentration, and poor memory retention.

ACTION ON BEHAVIOR: Gasoline inhalation causes a lack of balance and stumbling behaviors.

ACTION ON SENSATION: Gasoline inhalation causes feelings of dizziness and loss of balance.

DOSE LEVEL CONSIDERATIONS: There has been little documentation in this area. However, it appears that repeated inhalation, especially of gasoline, could result in brain damage.

OVERDOSE POTENTIAL: Repeated inhalation of gasoline can result in seizures.

TOLERANCE: There does not appear to be tolerance build-up with inhaled compounds.

WITHDRAWAL: There does not appear to be a withdrawal pattern with inhalants.

POTENTIAL FOR CHEMICAL DEPENDENCY: Suspected to be low.

OTHER CONSIDERATIONS: The loss of coordination when using inhalants often results in falls and accidents for the user. Because many inhalants temporarily shut off oxygen to the brain, brain damage is suspected as a side effect of the use of these inhalants.

STEROID WORKSHEET

CLASSIFICATION:

ROUTES OF USE:

MIXING PATTERNS WITH OTHER DRUGS:

ACTION ON THE EMOTIONS:

ACTION ON COGNITION:

ACTION ON BEHAVIOR:

ACTION ON SENSATION:

DOSE LEVEL CONSIDERATIONS:

OVERDOSE POTENTIAL:

TOLERANCE:

WITHDRAWAL:

POTENTIAL FOR CHEMICAL DEPENDENCY:

OTHER CONSIDERATIONS:

STEROID REFERENCE

CLASSIFICATION: The term "steroid" for the most part refers to the over 200 chemical compounds called Anabolic-Androgenic Steroids, all of which are very similar in nature to the male hormone testosterone. Being a hormone-like substance, the actions of steroids are different from any other drugs. Steroid use results in increases in lean muscle mass and strength, thus they are especially attractive to adolescent males. Side effects of steroid use remain mostly unknown since some of the 200 steroids may have different short term and long term effects.

ROUTES OF USE: Steroids are usually injected into muscle tissue.

MIXING PATTERNS WITH OTHER DRUGS: Because steroids are not really used to change an emotional state, mixing with other drugs is not common. However, since there are over 200 known chemical variations of androgenic steroids, mixing of these various steroids is certainly possible. Steroid users usually find their drugs with connections they make with other body builders in gyms. The quality and identity of the various steroids are unknown to the buyer and most probably also to the steroid dealer. For the most part, the body building community that uses steroids is unaware of the vast range of steroid products.

ACTION ON THE EMOTIONS: For several years the popular press, the steroid-using community, and some prevention materials have indicated that use of steroids leads to violent outbursts of rage which has been called "roid rage". The symptoms of "roid rage" are sudden anger and nonsuppressible rage resulting in or exhibited by destruction of property with some potential for violence against others. In the small amount of research that has been done on this topic, there has not been any substantiation of this "roid rage". In a Chicago study of body builders, the steroid users reported the same number of angry outbursts as did the non-steroid users. There is considerable amount of evidence however that steroids create a sense of well being. This sense of wellbeing seems to be characterized by a general feeling of confidence, a sense of healthy assertion, and an optimistic attitude. This sense of well being is not the same elated high received through cocaine or stimulants.

ACTION ON COGNITION: There has been some evidence that elderly men who are given steroids improve in both concentration and memory recall. Expect that in the next few years there will be increased use of steroids for the treatment of signs of aging in males.

steroidr

ACTION ON BEHAVIOR: Because steroids make a person literally stronger, more lean, with less fat, they may indirectly impact behavior. Athletic performance is enhanced and fatigue is reduced.

ACTION ON SENSATION: There has been little if any documentation that steroids impact sensation.

DOSE LEVEL CONSIDERATIONS: Again, there has been little documentation in this area. Steroid shooters in gyms have little idea of the dose they have purchased or the dose they are injecting. They have little idea whether they have injected a maximum amount or whether smaller amounts could result in the same muscle development. Because "roid rage" has yet to be documented, we have no idea the dose levels associated with this has yet to be fully documented state.

OVERDOSE POTENTIAL: Again, there has been little documentation in this area.

TOLERANCE: Since Steroids are hormone-like substances tolerance may or may not play a role in their use. There has been little research or documentation in this area.

WITHDRAWAL: There does not appear to be a withdrawal pattern with steroid use. In fact, steroid users tend to go through use and non-use cycles in an effort to maximize muscle building.

POTENTIAL FOR CHEMICAL DEPENDENCY: Suspected to be low.

OTHER CONSIDERATIONS: Numerous athletes in their 40s who used steroids for many years are developing a broad range of chronic and life threatening diseases. Many of these athletes attribute their diseases to steroids. This may or may not be true. A world of research remains to be done on steroids.

BEHAVIORAL SIGNALS WORKSHEET

Young people may present behavioral signs that indicate they wish to talk about drugs and alcohol. Some of these may include:

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BEHAVIORAL SIGNALS REFERENCE

Young people may present behavioral signs that indicate they wish to talk about drugs and alcohol. Some of these may include:

1. Hanging around, seeming to want to talk, but hesitating to do so.

2. Questions or concerns about a friend, as in "My friend tried marijuana and did not like it, but now her boyfriend wants her to try it again. What can she tell her boyfriend when he tries to get her to smoke it?"

3. Turning drug paraphanalia over to school officials as a way to open up the topic.

4. Talking about a decoy subject and then say "by the way" before starting to talk about the real topic they.

5. Coming to school to early or staying too late.

6. Elementary students may draw pictures for school personnel that alert the person that the child has a conflict and needs to talk.

7. Allowing school personnel to "overhear" a provocative statement they know will be related to the school counselor or school nurse.

8. Creative writing projects reveal conflicts or a need to talk.

9. Frequent health room visits or health complaints.

10. Hypothetical questions such as, "What would happen if ....?".

11. Getting caught in some minor violation so that they can talk to a school professional in a private setting.

ASKABLE ENVIRONMENT WORKSHEET

How do we create an askable environment for youths to ask questions about drugs and alcohol, whether in group or individual settings.

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ASKABLE ENVIRONMENT REFERENCE

How do we create an askable environment for youths to ask questions about drugs and alcohol?

1. Posters on the wall regarding drug and alcohol prevention.

2. Brochures or pamphlets on drug and alcohol prevention and/or drug and alcohol abuse in the office where students can reach them in an accessible area.

3. Offices that are comfortable where desks do not separate the student from the school worker.

4. Offices that are private with a closing door.

5. Indications that the staff is "Pro Youth" with bulletin boards, magazines, student art, etc. in the office.

6. Develop a Peer Helper program to increase the number of "ears".

7. Anonymous Suggestion/Question Box for the school

8. Focus on Prevention Programs so that students know they can ask about Drug and Alcohol Prevention.

9. Educate the community and parents so that we create social norms that support questions about Drug and Alcohol Prevention.

10. Take advantage of "Teachable Moments".

11. Provide Helpline Numbers.

KEY SKILLS FOR COUNSELING WORKSHEET

Think about the communication skills you use when you work with students. Think about what works? What does not work? Take a few minutes to list the skills you use:

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KEY SKILLS FOR COUNSELING REFERENCE

Think about the communication skills you use when you work with students. Think about what works? What does not work? Below are a list of some key skills we think work:

1. Use active listening. This means reflect back to the student what you hear being said. Active listening also means focusing on the student rather than on formulating your next response while the student is talking.

2. Be direct.

3. Use drug terminology with which you are comfortable. Don't use any drug slang if you are unsure of the terms. Don't use drug slang just to give the impression you are "hip".

4. Be aware of your biases, judgements, values, and fears. A "no use" or "complete abstinence" message can be conveyed to a student while at the same time indicating that you are willing to hear what they have experienced.

5. Maintain an "open door policy".

6. Clarify terms that you don't understand. For example: "What is a bong?" "What do you mean by the term Primo?"

7. Learn how to use your discomfort. This may mean saying: "I have trouble saying to you that ...."

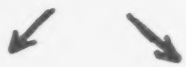
8. Inform students of their right to confidentiality.

keyskill

Legal/Ethical Issues in the School

- A Legal decision involves interpretation of law or policy.
- An Ethical decision involves a choice between two or more competing "goods."

PROBLEM



IS IT A LEGAL PROBLEM

Sources of Information

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4.

5.

IS IT AN ETHICAL PROBLEM

Sources of Information

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2

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Two levels of Ethical Decision Making

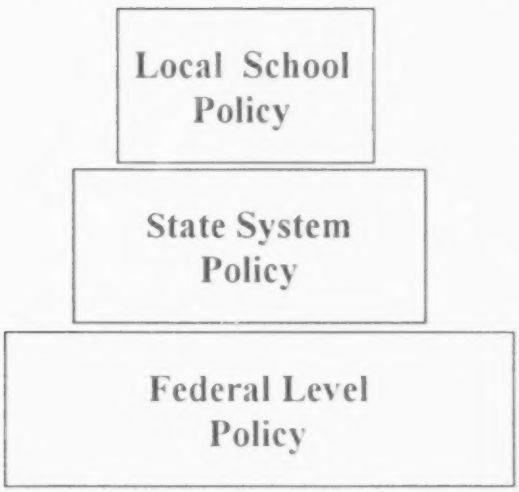
Aspirational Ethics - *Concern for the Best Interest of the Client*

Mandatory Ethics - *Meeting the Minimal Standard of the Law*

All School Personnel Must Ask: - *"Is My Decision In The Best Interest of The Child?"*

ethical

Foundations for School Professionals Concerned With Drug and Alcohol Abuse Prevention and Referral

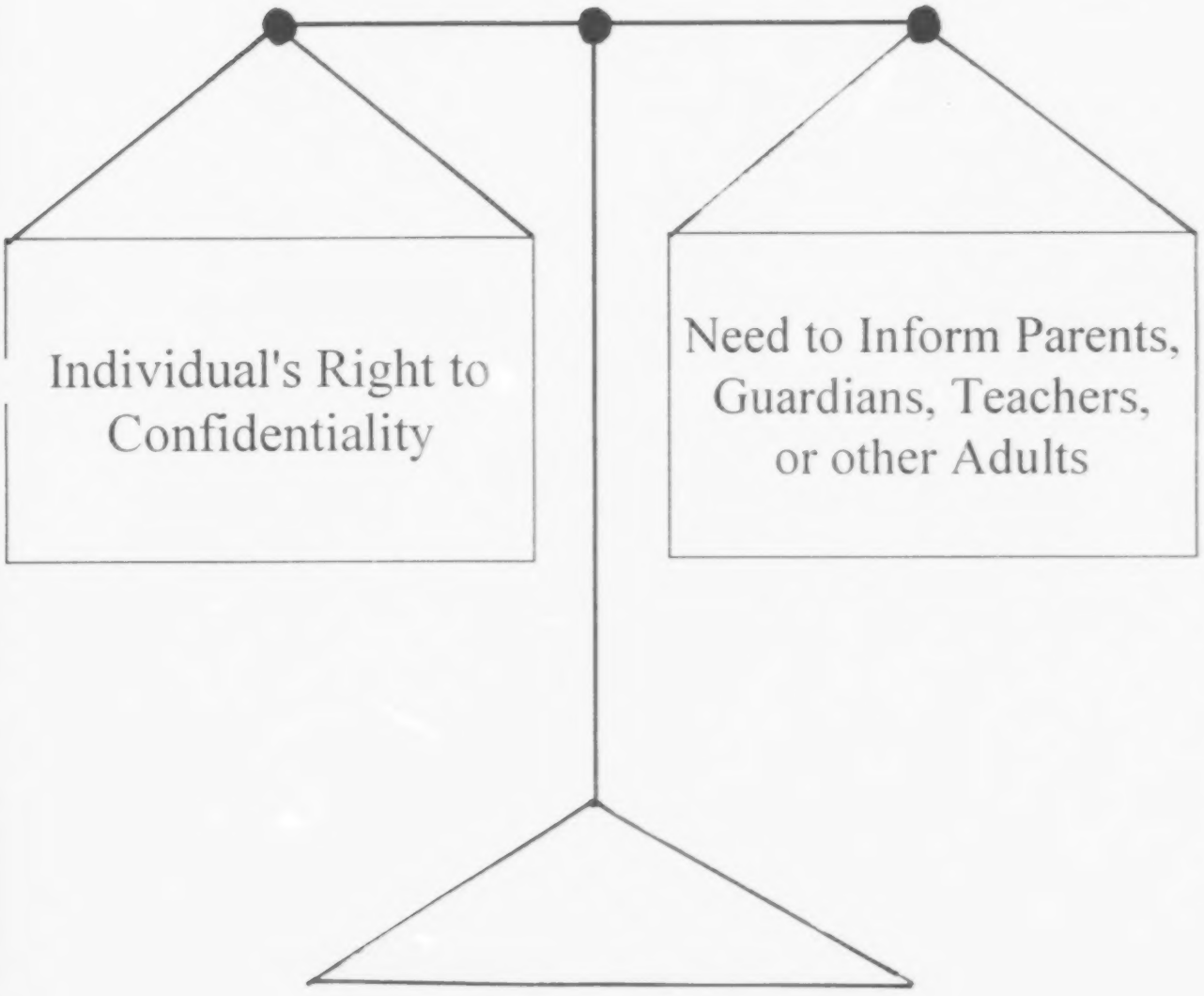


1. Know your local policy prior to action.

2. Consult with knowledgeable peers prior to action.

3. Consult with administrators prior to action.

The Confidentiality Dilemma



THE CONFIDENTIALITY QUESTION

When a child or youth brings a drug or alcohol related problem to school personnel, one important first questions the personnel must ask is: Can this information remain confidential?

What are some examples of information that can be told to school personnel that can remain confidential?

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addendum

BALANCING THE STUDENT'S RIGHTS TO CONFIDENTIALITY AND THE PARENT'S RIGHTS TO KNOW

Take each of the examples given in the previous exercise and identify a condition/event that would necessitate informing a parent. Conditions that would necessitate informing a parent:

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addendum

REVEALING INFORMATION OBTAINED FROM A STUDENT

When must school personnel reveal information told to them by a student?

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addendum

PRIVILEGED COMMUNICATION

Definition: Privileged Communication is a legal right that exists by state statute and protects pupil clients from having their confidential communications disclosed in court without their permission.

1. Does Alabama have "privileged communication" statutes?

2. Do they apply to school counselors?

3. Do they apply to school nurses?

4. Do they apply to school psychologists?

addendum

CONSENT TO DISCLOSE INFORMATION

It is strongly suggested that parents be involved early when children and youths bring problems involving drugs and alcohol to the attention of the school counselor, the school nurse or the school psychologist.

The school professional should obtain/secure the pupil's consent to disclose information if at all possible.

How can this be done in a way that is respectful of the rights of the pupil?

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ACTIVE PARENTAL PERMISSION

Active Parental Permission is strongly suggested before including a child in a Drug and Alcohol Prevention Curriculum or Program. How can schools ensure active parental permission has been given?

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addendum

INCREASING PARENTAL SUPPORT AND AWARENESS OF PREVENTION ACTIVITIES

How can schools make parents more aware of and increase parental support of drug and alcohol prevention activities?

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addendum

RESPONSIBILITY FOR REFERRAL

School counselors, school nurses, and school psychologists sometimes refer youths to drug/alcohol treatment programs. However, there have been many instances where the parents refuse to pay for the treatment and the local school system has been held responsible for the medical charges. How can the school professional help a young person receive needed drug treatment services without creating a financial liability for the school system?

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addendum

RECOMMENDING ASSESSMENT VERSUS RECOMMENDING TREATMENT

In what ways is recommending "Assessment" different from Recommending "Treatment"?

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addendum

A DEVELOPMENTAL APPROACH TO SUBSTANCE ABUSE PREVENTION

ANSWERING THE QUESTION: Why is it that those adolescents who experiment with drugs at a later age (ages 18 and 19) are better able to stop drug use and return to a no-use lifestyle than are those youth who began drug experimentation early (ages 12 to 15)?

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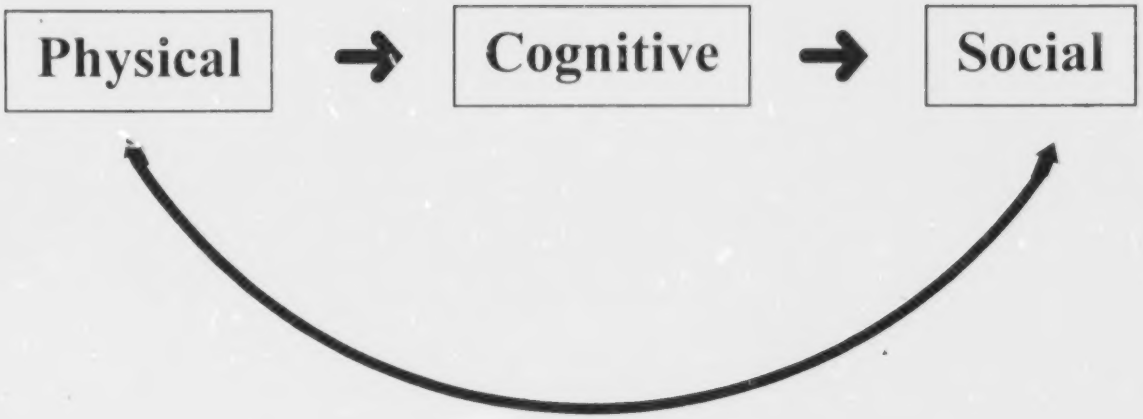
The Developmental Approach to Understanding Human Behavior



"In what ways can the 'stage be set' for a child to use drugs or alcohol?"

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A MULTIFACTORIAL APPROACH TO DRUG AND ALCOHOL USE BY ADOLESCENTS

INDIVIDUAL COMPETENCY FACTORS:

1. STAGE OF EMOTIONAL DEVELOPMENT
2. STAGE OF COGNITIVE DEVELOPMENT
3. BEHAVIORAL SKILLS ACQUIRED SUCH AS REFUSAL AND ASSERTION SKILLS
4. ABILITY TO UNDERSTAND CONSEQUENCES FOR BEHAVIOR

SUPPORT SYSTEM FACTORS:

1. USE OF SUBSTANCES BY PARENTS
2. USE OF SUBSTANCES BY SIBLINGS
3. USE OF SUBSTANCES BY SIGNIFICANT PEERS
4. COMMUNITY NORMS REGARDING USE AND NONUSE OF SUBSTANCES
5. PARENTAL SUPERVISION AND PARENTING SKILLS

STRESSORS IN THE COMMUNITY:

1. AVAILABILITY OF SUBSTANCES OF ABUSE IN THE COMMUNITY
2. POVERTY, CRIME, VIOLENCE AND OTHER STRESSORS IN THE COMMUNITY

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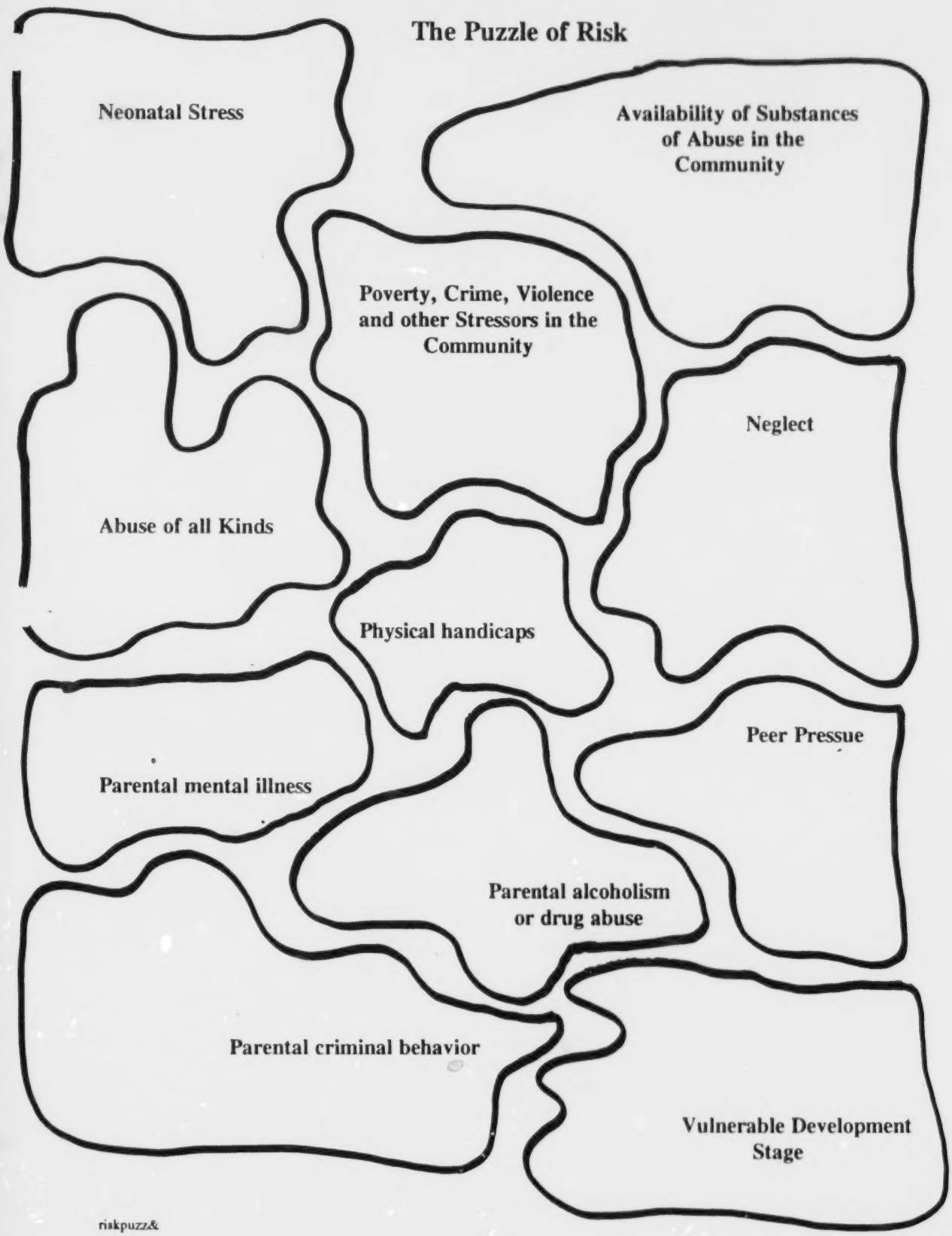
The Puzzle of Risk
Neonatal Stress
Availability of Substances of Abuse in the Community
Poverty, Crime, Violence and other Stressors in the Community
Neglect
Abuse of all Kinds
Physical handicaps
Peer Pressue
Parental mental illness
Parental alcoholism or drug abuse
Parental criminal behavior
Vulnerable Development Stage
riskpuzz&

"Observing a Drawing"

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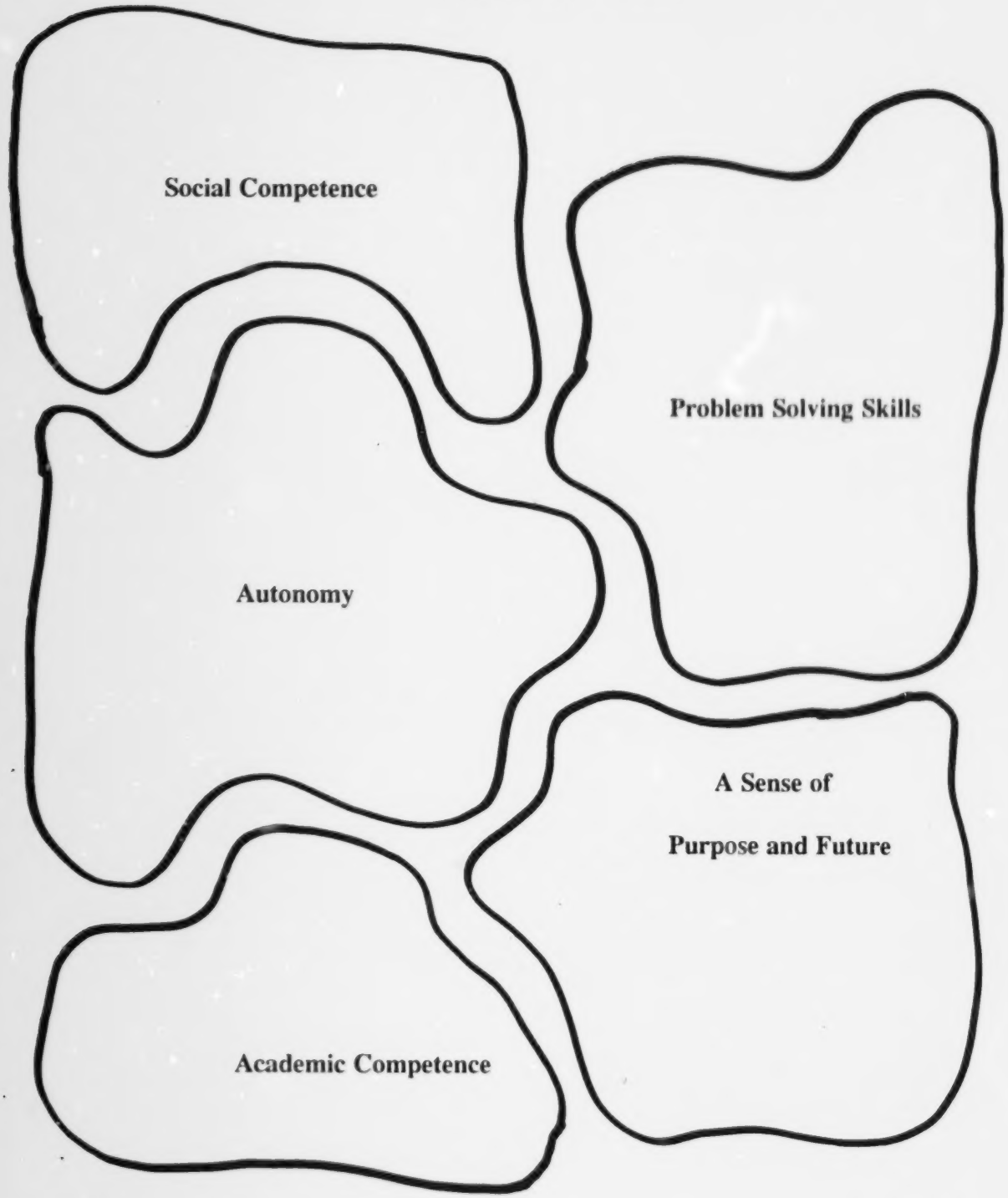
Resiliency Puzzle



resipuzz

Resiliency Puzzle:

"works well, plays well, loves well, and expects well"

Social Competence:

Responsiveness and can elicit more positive responses from others

Flexibility and Adaptability

Empathy

Caring

Communication Skills

A sense of humor- can laugh at themselves and ridiculous situations

Active

Problem-Solving Skills:

Can find alternative ways to look at things and attempt alternate solutions for both cognitive and social problems

Ability to think abstractly, reflectively, and flexibly

Planning skills

Academic Competencies:

Mastery

Age-appropriate academic skills

Student impowerment to learn

Autonomy:

Strong sense of independence and ability to act independently

Internal locus of control

Sense of power and ability to exert some control over one's e

Self-esteem

Self-efficacy

Self-discipline

Impulse control

A sense of one's own identity

Ability to distinguish clearly between themselves and their ov
illness or maladaptive behavior

A Sense of Purpose and Future:

Healthy expectations

Goal-directedness

Success Orientation

Achievement Motivation

Educational aspirations

Persistence

Hopefulness

Hardiness

A sense of anticipation

A sense of coherence and that one's internal and external envir

Taking responsibility for our ability to influence the future

ependently

ver one's environment

nd their own experiences and their parent's

ernal environment is predictable

future

Protective Factors Within the Family

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Protective Factors Within the Family

Caring and Support Factors:

1. The opportunity to establish a close bond with at least one person who provided them with stable care and from whom they received adequate and appropriate attention during the first year of life.

2. A caring and supportive relationship.

3. Having a warm and affectionate father or mother was significantly associated with adult social accomplishment.

4. A good relationship with one parent.

5. A sense of basic trust.

6. The enduring loving involvement of one or more adults in care and joint activity with the child.

High Expectation Factors:

7. High parental expectations.

8. A parental attitude that sees clearly the potential for maturity, common sense, for learning and well-being in their children.

9. An attitude expressed to the child of: "You have everything you need to be successful - and you can do it."

10. The family environment that validates the child as a worthwhile human being by giving the message:"You will be heard, you will usually be able to protect your legitimate self-interests, and we all understand that no human is faultless."

11. Structure, discipline, and clear rules and regulations.

12. A belief that things will work out in the end, despite unfavorable odds.

Protective Factors Within the Family (cont'd)

Encouraging Children's Participation Factors:

13. Many opportunities for the children to participate and contribute in meaningful ways.

14. Assigned chores, domestic responsibilities (including care of siblings) and even part-time work to help support the family prove to be sources of strength and competence.

15. Respect for the child's autonomy.

16. Encouragement of the child's independence.

The Authoritative Family as a Family Protection Factor

Baumrind (1985) found that the Authoritative family had lower rates of drug and alcohol use than either the Authoritarian Family or the Permissive Family. Some of the characteristics of these three family patterns are listed below:

Authoritarian Family	Authoritative Family	Permissive Family
Harsh discipline	Discipline fits the offense	Inconsistent discipline
Many rules	Clear rules	Few rules
Unrealistic expectations	Clear, realistic expectations	Few expectations

Source: Baumrind, Diana. Familial antecedents of adolescent drug use: a developmental perspective. In Etiology of Drug Abuse: Implications For Prevention (NIDA Research Monograph 56), ed. by Coryl Jones and Robert Battjes. Washington, DC; USGPO, 1985. 13-44.

authorit

Protective Factors Within the School

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Protective Factors Within the School

Research evidence indicates that the school can serve as a protective shield to help children withstand the stressors and risks, whether they come from a family impacted by alcoholism or mental illness or from a community impacted by poverty, crime and violence.

Caring and Support Factors:

1. Among the most frequently encountered positive role models in the lives of children, outside of the family circle, was a favorite teacher.

2. Peer programs, including cooperative learning strategies, are the single most effective school-based approach for reducing alcohol and drug use in youth.

High Expectation Factors:

3. Successful schools share the characteristics of: an emphasis on academics, clear expectations expressed by the teachers, high levels of student participation, and many varied alternative resources such as library facilities, vocational work opportunities, art, music, and extra-curricular activities.

4. Schools that foster high self-esteem and that promote social and scholastic success reduce the likelihood of emotional and behavioral disturbance.

5. Engaging students at risk for school failure in a challenging curriculum has positive academic and social outcomes.

6. Internalization of high expectations for oneself.

Youth Participation and Involvement Factors:

7. Successful schools provide students with opportunities to participate and be meaningfully involved and have roles of responsibility within the school environment.

8. Offering the students the opportunity to respond.

9. To engage youth by providing them opportunities to participate in meaningful, valued activities and roles, those involving problem-solving, decision-making, planning, goal-setting, and helping others.

10. Participation is more than the formal sharing of decisons; it is an attitude characterized by cooperation, dialogue, and empathy.

Protective Factors Within the Community

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Protective Factors Within the Community

The term "community competence" is often used to mean the capacity of a community to build resilient youth. A competent community must have clear no use norms and encourage the active participation and collaboration of its families and schools in the life and work of the community.

Caring and Support Factors

1. The availability of social networks within the community that can promote and sustain social cohesion within the community. These formal and informal networks allow individuals to develop their competencies and provide links within the community which serve as a source of strength. Communities and neighborhoods rich in social networks - both peer groups and intergenerational relationships - have lower rates of social problems such as delinquency, child abuse, drug and alcohol addiction, and teen pregnancy.

2. The availability of resources necessary for healthy human development such as health care, child care, housing, education, job training, employment, and recreation. One of the greatest protective factors is ensuring that children and their families have access to these basic necessities.

High Expectation Factors

3. Cultures that have as a norm the valuing of youths as a resource rather than as a problem tend to have less behavior problems.

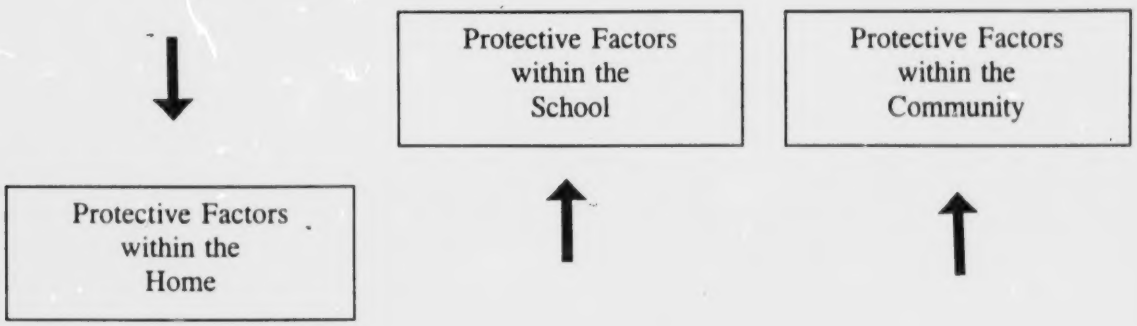
4. Cultures that stigmatize "drunkenness" have lower rates of alcoholism.

Opportunities for Participation Factors

5. A community's ability to create opportunities for youths to be contributing members of the community allows the development of a sense of belonging and attachment to the community. Youths who participate in socially and/or economically useful tasks have heightened self-esteem, enhanced moral development, increased political activism, and the ability to create and maintain complex social relationships.

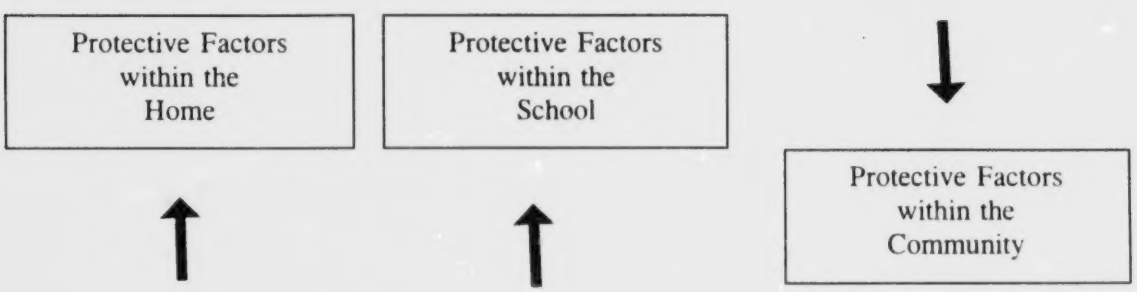
The Vital Role of School Protective Factors in the Balance of Protective Factors

When there is a problem in the home, such as alcoholism:



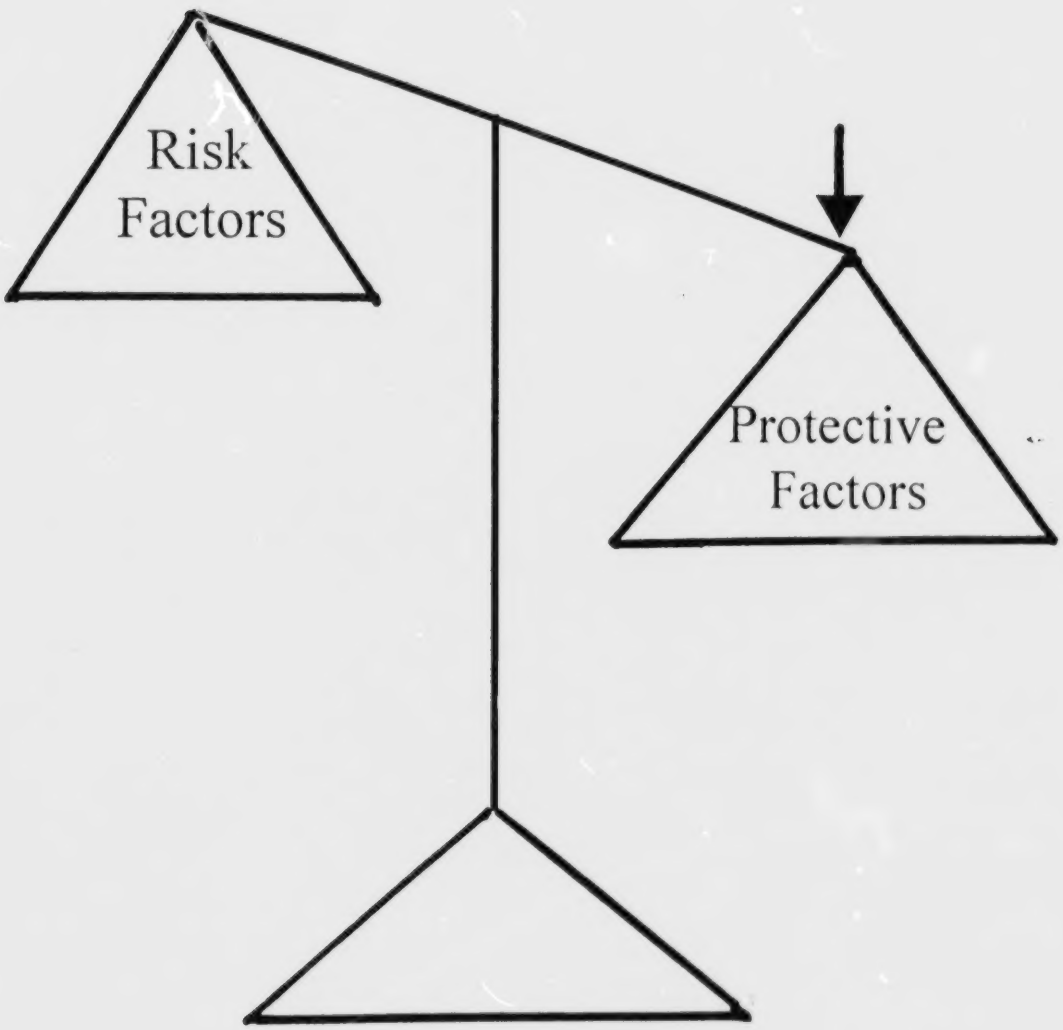
OR

When there is a problem in the community, such as poverty:



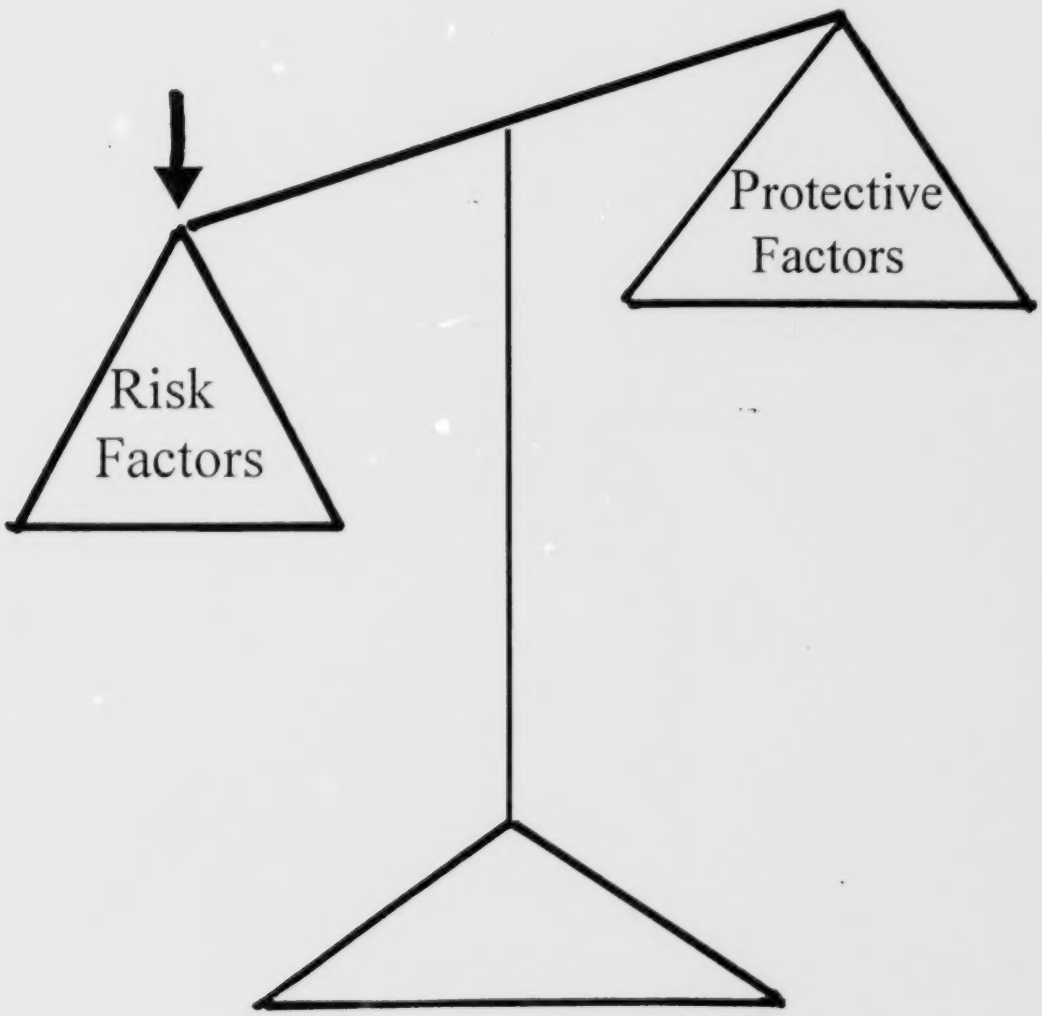
RESILIENCY PROFILE

Shifting the scales from vulnerability to resilience can happen as a result of one person or one opportunity.



VULNERABILITY PROFILE

When stressful life events begin to outweigh protective factors, even the most resilient child can develop problems.



THE SMITH FAMILY

MR. SMITH

MRS. SMITH

ALAN

BEN

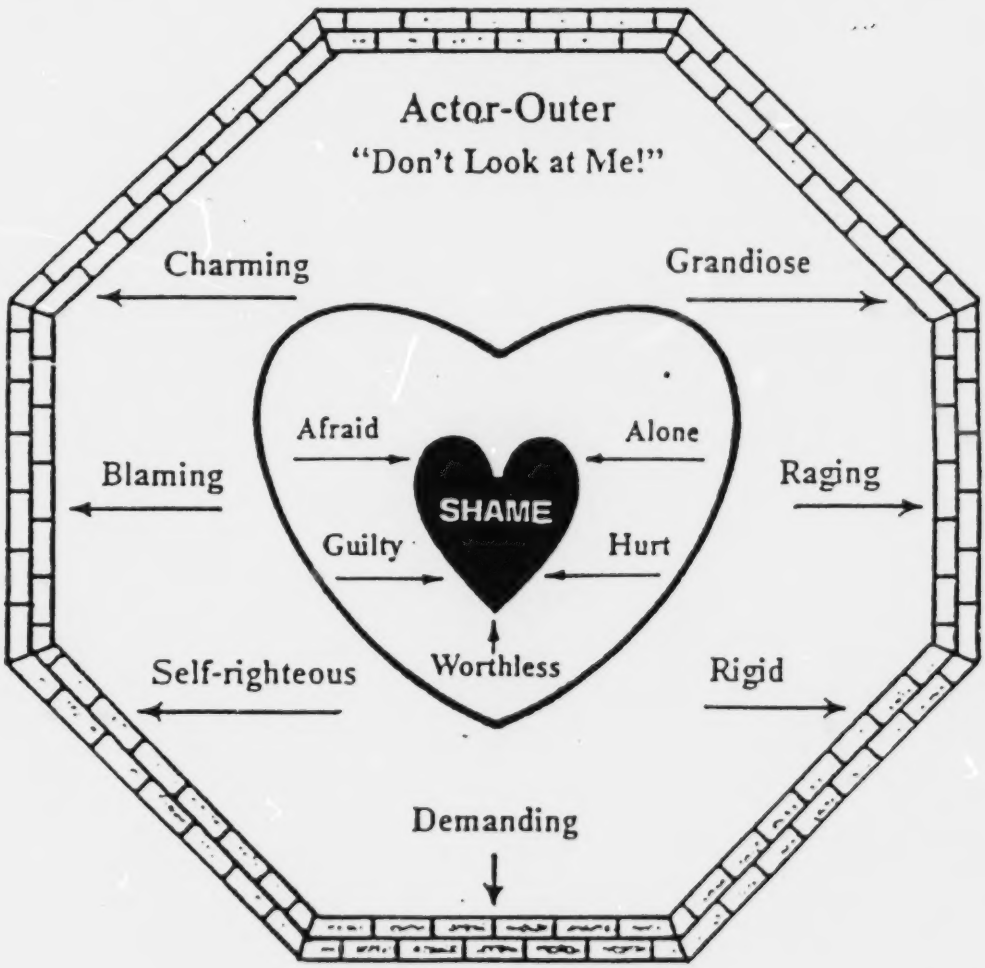
CHARLIE

DENISE

addendum

THE CHEMICAL OR BEHAVIORAL ADDICT

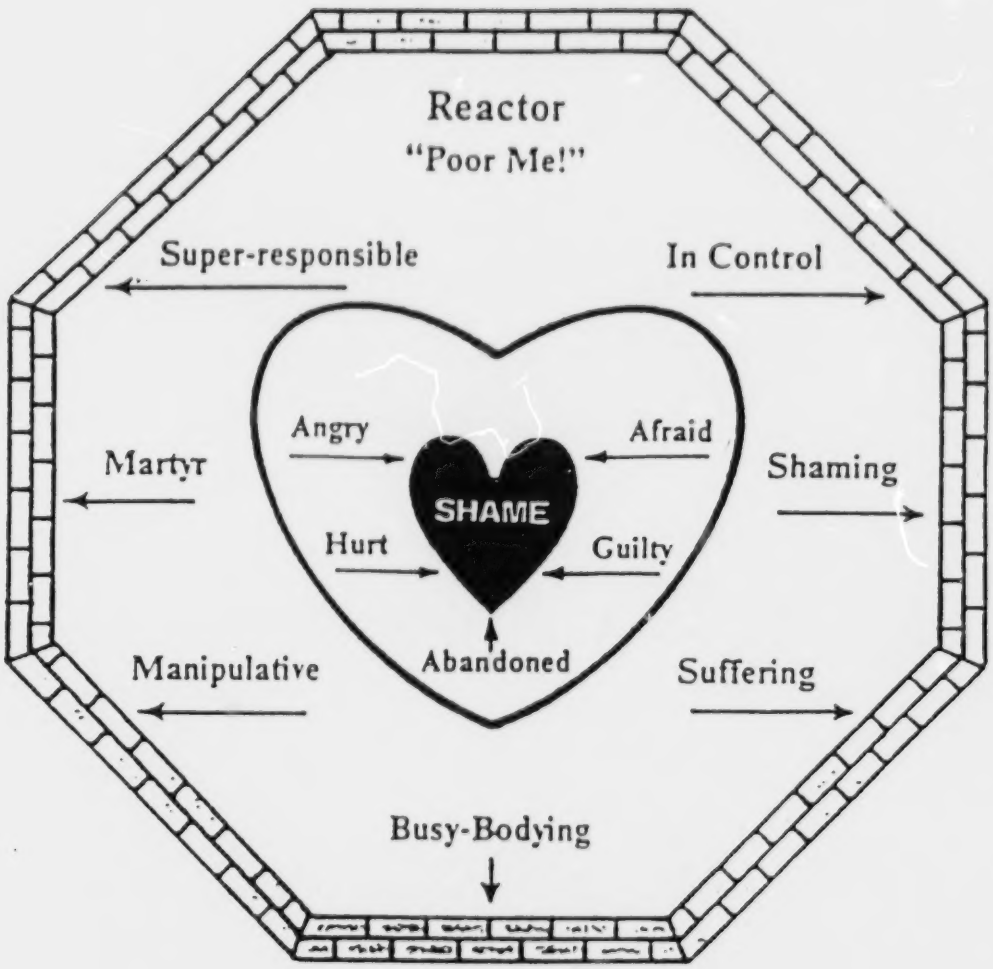
The Chemically Dependent Addict's Job: Create the Chaos to which Everyone Else Reacts.



Source: The Winner's Circle: Drug Free Schools and Communities, Oklahoma State Department of Education, 1994.

THE CHIEF ENABLER

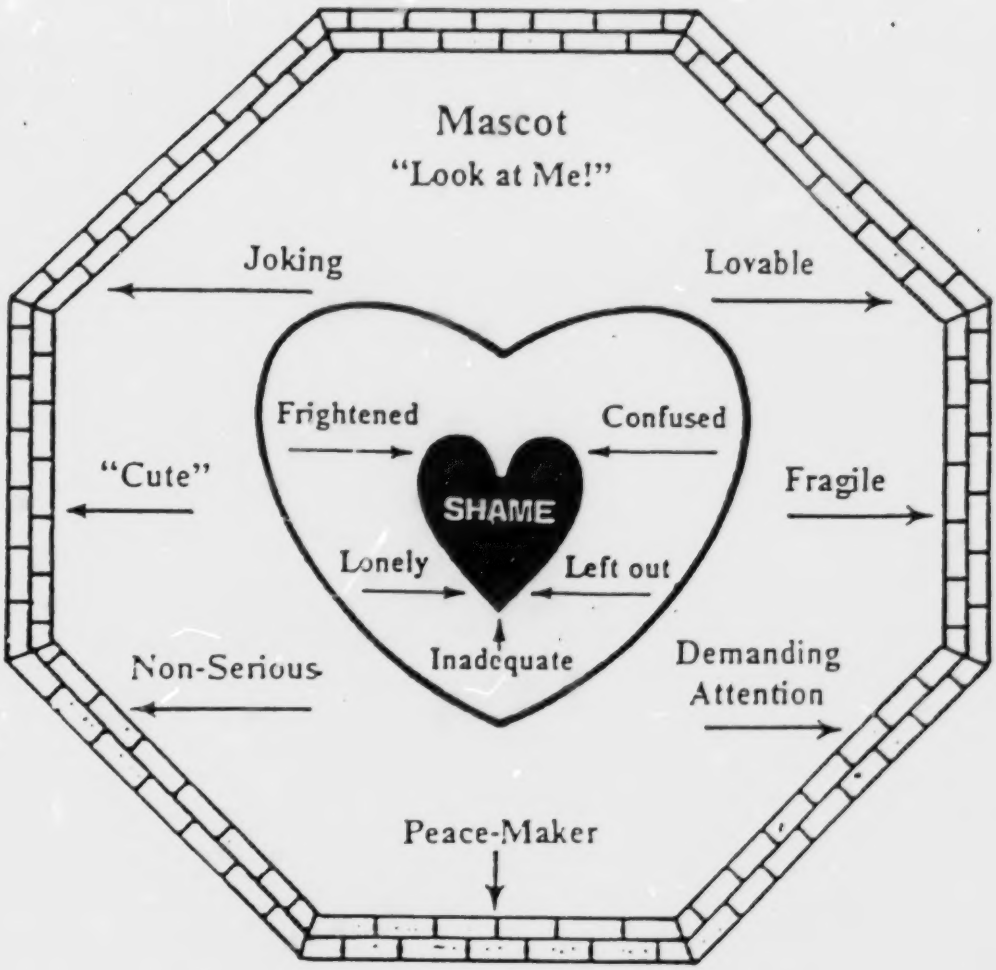
The Chief Enabler's Job: Maintain Control at Any Cost.



Source: The Winner's Circle: Drug Free Schools and Communities, Oklahoma State Department of Education, 1994.

THE MASCOT

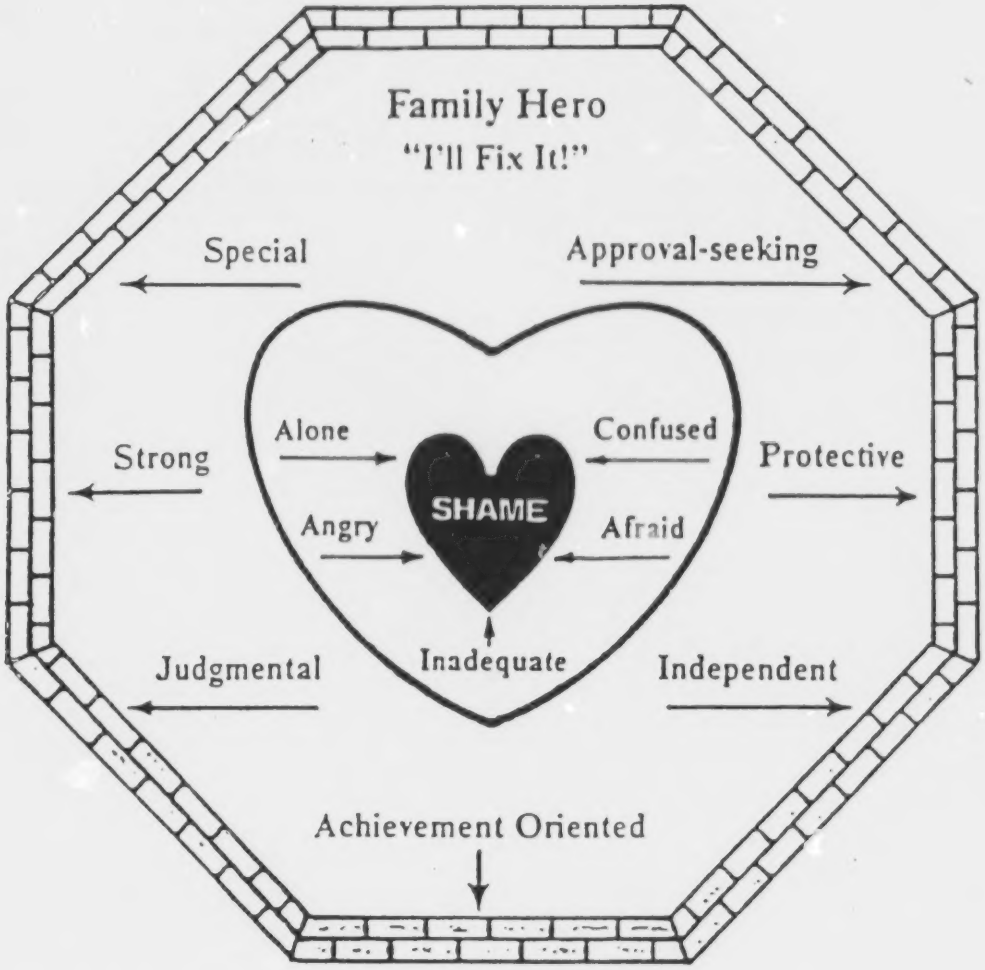
The Mascot's Job: **Provide Diversion from the Problem by Entertaining Others.**



Source: The Winner's Circle: Drug Free Schools and Communities, Oklahoma State Department of Education, 1994.

THE FAMILY HERO

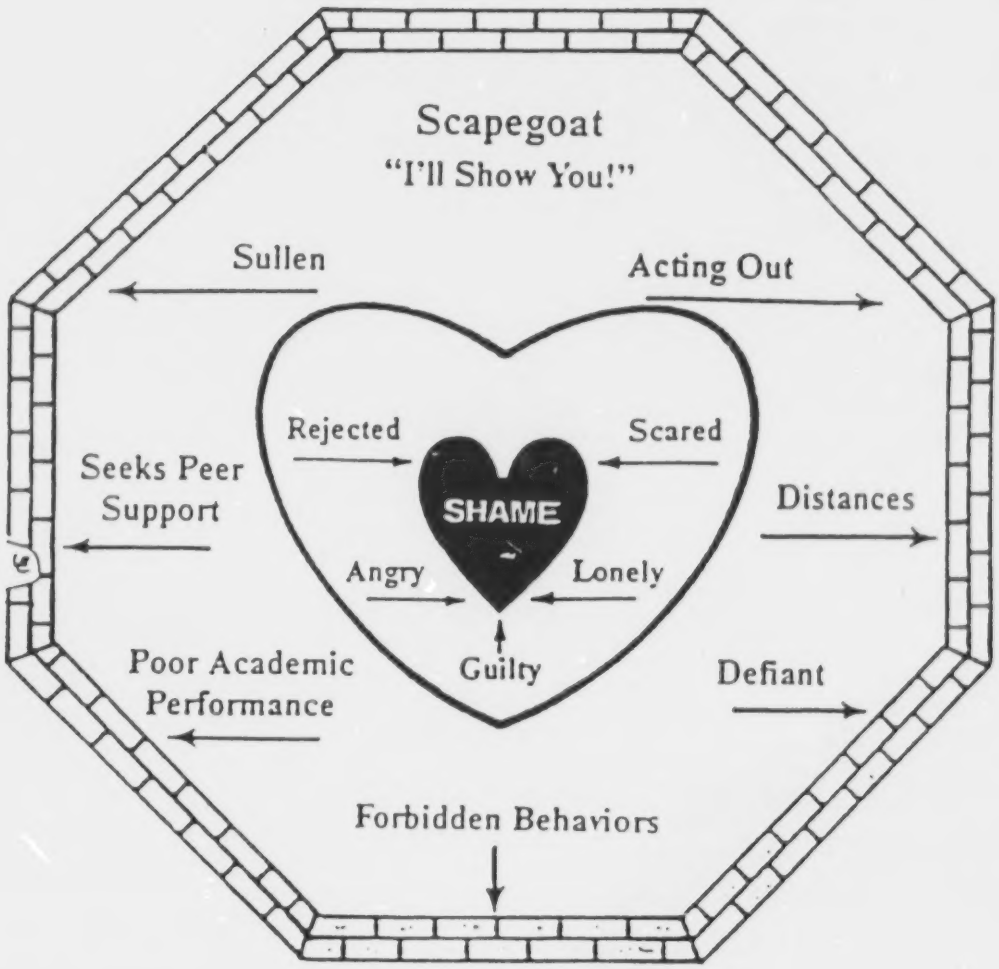
The Family Hero's Job: **Fix Everything and Make the Family Look Good.**



Source: The Winner's Circle: Drug Free Schools and Communities, Oklahoma State Department of Education, 1994.

THE SCAPEGOAT

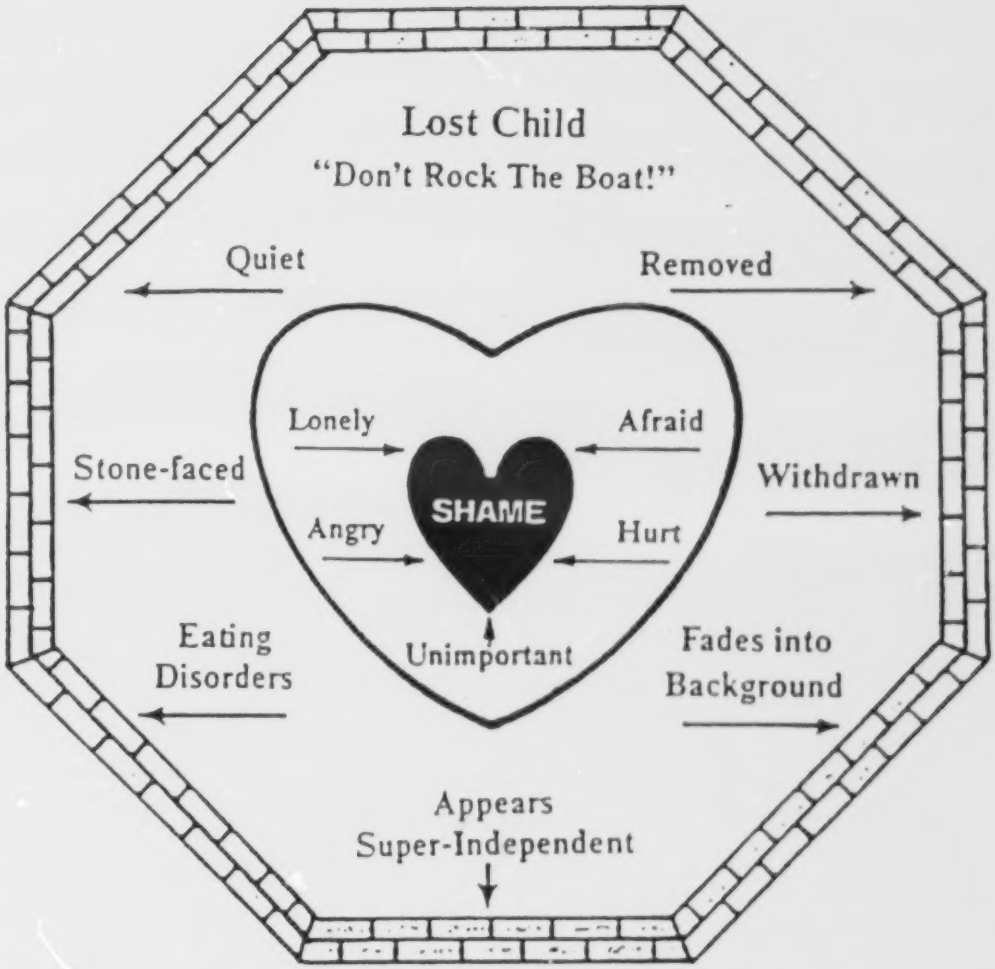
The Scapegoat's Job: **Provide a "Dumping Ground" for the Family's Anger--Enabling Everyone Else to Feel Superior.**



Source: The Winner's Circle: Drug Free Schools and Communities, Oklahoma State Department of Education, 1994.

THE LOST CHILD

The Lost Child's Job: **Being the Person No One Has to Worry About.**



Source: The Winner's Circle: Drug Free Schools and Communities, Oklahoma State Department of Education, 1994.

Identification of COA in the Classroom

1.

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10.

contd

What critical messages must school personnel convey to COA?

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10.

coaid

IDENTIFYING CHILDREN OF ALCOHOLICS IN THE CLASSROOM

It is important to consider that no one indicator listed below is sufficient for the identification of COAs in schools. However, when several of these are present and a change in behavioral patterns occurs, it may suggest a parental drinking problem. It is also critical that school personnel examine their personal involvement with alcohol in order to assure objectivity.

1. **"Acting Out" Behavior** - inappropriateness in class, threats of violence to school personnel, substance abuse, vandalism, etc.

2. **Social Withdrawal** - loners, learning difficulties, constant daydreaming, concern of getting home on time, avoidance of argument and conflict.

3. **Hyperactivity** - clowning in class, disruptive behavior, seeking attention, avoidance of going home, etc.

4. **Over achievement** and constantly seeking approval for it.

5. **Appearance** - inappropriate clothing for weather, lack of personal hygiene, etc.

6. **Physical Conditions** - bruises, hunger, and fatigue.

7. **Academic performance** - inconsistence, sporadic variation of achievement without noticeable reason, especially towards the end of the day and/or week.

8. **Report Cards** - signatures of parents varies; especially pertinent when questioned by teachers and student replies with negative "body language."

9. **Peers** - lack of peers; silent in class; walk by themselves in halls; constant loners by force, not choice, especially if friends know about drinking problem at home, etc.

Teachers and Counselors Can Help By:

1. **Listening** - this by itself helps because COAs need to verbalize and "let the dam burst." Hearing pain is not causing pain.

2. **Teaching** facts about alcoholism in a non-judgmental manner.

3. **Knowing** that parents rarely protest.

4. **Provide six critical messages:**

- You can't make your parents quit drinking.
- You are not alone and you can learn to cope.
- The drinking is not your fault.
- Alcoholism is an illness.
- There is help available to you.
- Alcoholics can recover.

Administrators Can Help By:

1. Providing inservice training to school personnel in order to sensitize them to the problems stemming from alcoholism as they apply to the children. This should include what they can and cannot do with COAs, emphasizing the support for the children and avoiding direct involvement with the problem drinking parent.

2. Development of resources that include state, county, and local programs dealing with substance abuse. Also explore alternatives that drug abuse agencies in the community may offer.

3. Policy support which would be formal or informal depending on the attitude of the community and district. If formalized, policies should include statements supporting the children because of educational implications and avoid involvement with parents. Schools are not in the rehabilitative business.

4. Program coordination - someone needs to be responsible for coordinating efforts by the school and community. This would prevent the school program from fragmenting and isolating itself.

5. Monetary support for educational material such as films, speakers, literature, etc.

Reference sources:

Ackerman, Robert J., Children of Alcoholics, 1978.

Stone, Frank. "Children of Alcoholic Parents, the Ignored Millions", Texas Commission on Alcoholism, 1977.

NIAAA. Research Monograph - 4. Services for Children of Alcoholics, 1979.

NIAAA. A Growing Concern: How to Provide Services for Children From Alcoholic Families, 1983.

Wegscheider, Sharon. Another Chance, Hope and Health for the Alcoholic Family, 1981.

idencoas

How do school personnel deal with a "Hero"?

1.

2.

3.

4.

5.

6.

7.

8.

familyro

HOW TO DEAL WITH A "HERO"

DEFINITION: Always volunteering and responsible; has compulsion to always be on top; has insatiable need for your attention and approval; leader of class; parental with other children; needs to help others; and is bossy. Disappointed when losing (depressed and down on themselves); superior when winning; is obnoxious and often called "teacher's pet" by others.

DO: Give attention at times child is not achieving.

Try to separate self-worth from achievements.

Let him/her know it's okay to make mistakes.

DON'T: Let them monopolize conversation.

Let them answer all questions.

Let them validate self-worth only through his/her achievements.

familyro

How do school personnel deal with a "Mascot"?

1.

2.

3.

4.

5.

6.

7.

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familyro

HOW TO DEAL WITH A "MASCOT"

DEFINITION: Funny or distracting, gets class attention, real clown, i.e., hiding, making faces, pulling chair out from under someone else, sticking chalk in erasers.

DO:

Hold child accountable for disruptive behavior.

Encourage responsible behavior by giving him/her a job in class with some importance, value, and responsibility.

Encourage an appropriate sense of humor.

DON'T:

Allow him/her to use laughter to manipulate or mask other feelings, such as fear.

Become so entertained with child's behavior that you never take him/her seriously.

How do school personnel deal with a "Lost Child"?

1.

2.

3.

4.

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7.

8.

HOW TO DEAL WITH A "LOST CHILD"

DEFINITION: Wallflower; extremely quiet, never a behavior problem; few, if any friends. Often creative - excels at art work and doing things alone. Often low verbal and written skills. Either left to themselves or teased about never getting involved, being "chicken," fat, etc. Others often have difficulty remembering child's name.

DO:

Notice children whose names or faces you can't even remember.

Try one-on-one contact.

Point out and encourage child's strengths, talents, etc.

Help child to build a relationship.

Encourage working in small groups.

DON'T:

Allow child to remain silent by never calling on him/her.

Let other kids take care of the child by talking and answering for him/her.

Praise student for their "quietness."

How to school personnel deal with a "Scapegoat"?

1.

2.

3.

4.

5.

6.

7.

8.

familyro

HOW TO DEAL WITH A "SCAPEGOAT"

DEFINITION: Blames; makes peer alliances; acts out; is irritating; displays rigid defiance; is irresponsible. Teacher puts child in hall a lot for disrupting class; child is sent to principal's office often for breaking rules, i.e., running in hall, talking back to teacher, hardly ever getting work done. Teacher feels "at end of rope," i.e., angry and frustrated, "I don't know what to do with that child!," "I've tried everything!"

DO:

Let child know when behavior is not appropriate.

Validate him/her when he/she takes responsibility.

Set limits and give clear explanations of responsibilities, choices, and consequences.

Consistently follow through with all consequences.

DON'T:

Feel sorry.

Treat differently or give more power.

Agree with complaints about others.

Take behavior personally.

How do school personnel deal with an "Enabler"?

1.

2.

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HOW TO DEAL WITH AN "ENABLER"

DEFINITION: In a chemically dependent family, the enabler is an individual who reacts to the symptoms of the illness by shielding the chemically dependent person from the full impact of the disease.

DO: Encourage attendance in a self-help group such as AL-Anon.

Encourage participation in hobbies and other behavioral areas of interest apart from the chemically dependent person.

Support the need to develop and implement a "bottom line" for the chemically dependent person.

DON'T: Praise them for "going the extra mile" or "taking care of" a chemically dependent person.

Reinforce their need to be in control or seek positions of "power."

Sympathize with their complaints regarding the chemically dependent person.

CHILDREN'S ROLES CARRIED INTO THE CLASSROOM
HOW TO DEAL WITH A CHEMICAL ADDICT

DEFINITION: Dependence on substances has disrupted academic performance, school attendance, relationships with friends and family, and overall health.

DO:

Face up to the fact that chemical dependency must be dealt with honestly and forthrightly.

Accept alcoholism as a treatable illness.

Encourage the individual to seek help.

Familiarize yourself with referral sources.

Be firm in your relationship.

DON'T:

Let yourself be ruled by the addict's behavior.

View the addict as lacking backbone or willpower.

Make threats you are not willing to back up.

Confront the addict while he/she is under the influence.

Make excuses to school authorities or family members regarding behaviors.

familyro

MAJOR AREAS OF CONCERN FOR CHILDREN OF ALCOHOLICS BY AGE

Children

1. Worry about the health of the alcoholic parent.
2. Are upset and angry by the unpredictable and inconsistent behavior of the alcoholic parent and the lack of support from the non-alcoholic parent.
3. Worry about fights and arguments between the parents.
4. Are scared and upset by the violence or the possibility of violence in the family.
5. Are disappointed by broken promises and feeling unloved.
6. Feel responsible for their parent's drinking.

Adolescents

1. Are concerned about their own substance abuse and if alcoholism is hereditary.
2. Are concerned about the health of the alcoholic parent or how to get that person to stop drinking.
3. Worry about how to survive their parent's troubled relationship.
4. Are concerned about their family's alcoholism and its effects on their friendships, dating, and "reputation".
5. Worry about how to live with an alcoholic.
6. Are concerned about developing better survival skills for coping and getting help.
7. Are concerned about other issues that may be related such as abuse and incest.
8. Are concerned about how they may be affected by parental alcoholism.

Adults

1. Are concerned about their own addiction.
2. Worry about how to get their parent sober.
3. Want to improve their own relationships.
4. Want to improve the relationship between their parents and with their parents.
5. Worry about living with a spouse who is addicted.
6. Are concerned about other issues, such as being the victim of abuse, incest, or how they may be affected today.

(Developed by Robert J. Ackerman, Indiana University of Pennsylvania, 1984)

idencoas

INDICATIONS OF CHILDREN OF ALCOHOLICS DURING ALCOHOL EDUCATION

- Extreme negativism about alcohol and all drinking
- Inability to think of healthy, integrative reasons and styles of drinking
- Equation of drinking with getting drunk
- Greater familiarity with different kinds of drinks than peers
- Inordinate attention to alcohol in situations in which it is marginal: For example, in a play or movie that is not about drinking
- Normally passive child or distracting child becomes active or focused during alcohol discussions
- Changes in attendance patterns during alcohol education activities
- Frequent requests to leave the room
- Lingering after activity to ask innocent question or simply to gather belongings
- Mention of parent's drinking to excess on occasion
- Mention of drinking problem of friend's parent, uncle, or aunt
- Strong negative feelings about alcoholics
- Evident concern with whether alcoholism can be inherited
- Laughing at or "making fun" of alcoholic behaviors

Adapted from: Children of Alcoholics - Ackerman

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PROFESSIONAL ENABLING

The Professional Enabler:

1. Overlooks obvious problems
2. Avoids confrontation
3. Views self as self-sacrificing
4. Helps to remove consequences by minimizing the seriousness of the event
5. Controls under the guise of protecting and caring
6. Makes excuses for, covers, and even defends actions
7. Becomes frustrated because of inability to affect changes
8. Sometimes compromises own value system
9. Maintains the "no talk" rule
10. Labels, oversimplifies
11. Makes judgements based on narrow expertise
12. Gossips and accuses
13. Consistently maintains view of the chemically dependent individual as "one of **those** people"

The Helping Professional:

1. Holds the individual accountable for their behavior
2. Talks to individual regarding specific, identified behaviors which are disruptive and disturbing
3. Realizes limitations and accepts the fact that he cannot be "all things to all people"
4. Insures that each negative behavior there is a specific and consistent consequence
5. Is always aware of sudden changes in behavior
6. Seeks appropriate help for individual whose behavior suddenly changes
7. Doesn't jump to conclusions or diagnose individual's problems
8. Knows when to "let go" and let someone else take over
9. Always maintains high standards and values

10. Expresses care and concern at all times

11. Is open to a variety of possibilities as the cause of problems

12. Understands and accepts chemical dependency as a disease and the process of recovery

13. Discusses concerns with counselors, administrators, other staff members, or parents about specific behaviors

14. Is accepting and supportive of person who has been treated

15. Works to alleviate the system of professional enablers

How to Overcome Professional Enabling Behaviors in a School:

1. Become educated in the area of chemical dependency

2. Hold students and co-workers accountable for their behavior

3. Validate students as people - not by their behavior

4. Encourage and develop strengths and talents and allow students to make mistakes

5. Be aware of **sudden** behavior changes, drop in attendance, poor test scores, mood swings, etc., and seek appropriate help in handling the situation

6. Realize your limitations and accept that someone else may be better equipped to evaluate the situation

7. When the slightest suspicion creeps in regarding a student, talk to a counselor, administrator, or other teacher to gather data and share information

8. Work to alleviate the system of all professional enabling behaviors

9. Know when you have utilized all of your resources with a troubled individual, and "let it go"

10. Have interests outside of school

If a Child from an Alcoholic Home comes to You for Help

These suggestions will be especially helpful in implementing community or school prevention programs. Adults involved in such programs invariably meet children who need help. These guidelines will inform you about how to help.

DO follow through after the child asks for help. You may be the only person the child has approached about the family problem. Courses of action you might choose are:

- Help the child contact a local Alateen group where others who understand and share the problem of alcoholic parents are available for support;
- Assist the child in "thinking through" all the sympathetic adults who play significant roles in his/her life (a favorite aunt or uncle, grandparent, minister, school counselor) who might be able to help; and
- Refer the child to an appropriate helping professional.

DO develop and maintain a list of appropriate referrals, including Alateen and other helping professionals in your community. Knowing which organizations have resources to help children will make it easier when a child comes to you.

DO make sure that the child understands three basic facts:

- He or she is not alone; there are more than 7 million children of alcoholics under the age of 20 in the United States.
- The child is not responsible for the problem and cannot control the parent's drinking behavior.
- The child is a valuable, worthwhile individual.

DO maintain a small library of books and pamphlets on alcohol-related problems that have been written for children. Many of these are available at low or no cost from the National Clearinghouse for Alcohol and Drug Information, Alateen, and the National Council on Alcoholism.

DO be sensitive to possible cultural differences, as knowledge of these differences can help you more effectively counsel the child. It might be useful to explore the child's culture, including family structure, values, customs, and beliefs.

DO be aware that children of alcoholics may be threatened by displays of affection, especially physical contact.

DON'T act embarrassed or uncomfortable when the child asks you for help. It may be discouraging for the child and increase his or her sense of isolation and hopelessness.

This passage has bee excerpted from NCADI's "Children of Alcoholics Kit: Kit for Helpers." The complete COA set includes four parts: Kit for Kids, Kit for Parents, Kit for Therapists, and Kit for Helpers. For more information about ordering these, please call one of the Information Specialists at (301) 468-2600 and ask about COA kits.

STUDENT SUPPORT GROUP DESCRIPTION

"Staying Sober" Group

For students who desire to maintain a chemically free lifestyle and cannot stay sober without the support of this group.

"Discovery" Group

For students experiencing problems (family, school, friends) that may result from chemical use. Students may self-refer or choose group as an alternative to policy suspension.

"Concerned Persons" Group

For students who are concerned about the chemical use of a close friend or family member.

"Feelings" Group

For students wanting support for any concerns that are not related to alcohol and other drugs.

- Personal Growth Groups
- Transition Groups
- Eating Disorders
- School Leadership Groups
- Children of Divorce
- Non-use Support Groups
- Grief and Loss Groups
- Relationships
- Special Issues Groups

SUPPORT PROGRAMS FOR CHILDREN OF ALCOHOLICS

Support groups in the schools for children of alcoholics should be aimed at:

1. building self-esteem.
2. building a personality identity apart from the alcoholic.
3. establishing consistency.
4. encouraging healthy interaction between the child and other children and adults.
5. allowing the child to be open and honest in relationships.
6. expressing feelings openly.
7. learning to trust others.
8. being able to ask for adult help.
9. learning about "healthy touching and abusive touching."
10. teaching that it's "okay to be a child."

BENEFITS

1. Reduced Isolation
2. New Ways of Coping
3. Positive Peer Support
4. Practice Sharing Feelings
5. Confrontation When Needed
6. Increased Readiness for Alateen

SAMPLE GROUP CONTRACT

Group Goals are to:

1) Provide an opportunity for people to gain friendships with other sober people.

2) Establish a support system.

3) Encourage and allow people to work on individual goals.

4) Provide an opportunity for people to build self-esteem.

5) Provide feedback and confrontation.

6) Show care and concern.

7) Develop consequences for continuing harmful behavior.

8) Make people aware of defenses and how they use them.

9) Help people get in touch with their feelings.

Individual Goals are to:

1) Take responsibility for participation in group.

2) Be there on time.

3) Stay sober.

4) Be honest and open with the group.

5) Be responsible for attendance.

6) Write one's own contract and establish consequences when appropriate.

_____ _____

Facilitator Group Member

Date: _____

THE ROLE OF THE FACILITATOR IS TO:

provide a warm, safe, and trusting atmosphere by establishing the rules and structure of the group.

- give feedback on behavior.
- act as a positive role model who can appropriately self-disclose, setting the tone for group sharing.
- demonstrate the ability to listen.
- demonstrate the ability to communicate acceptance, respect, empathy, and concern.
- avoid rescuing, enabling, or fixing the pain.
- believe in each person's ability to make healthy decisions and assist in working through problems.

facilitate each person's own decision making process.

- be knowledgeable of the grieving process and support the expression of feelings.

RULES FOR FACILITATORS

- CONSISTENCY

  - Important to be there
  - Consistent with rewards and punishments
  - Do what you say you will do

- BE PREPARED!

  - Better to have more activities ready than you will use
  - Learn time fillers

- BE IN TOUCH WITH OWN VALUES AND FEELINGS

  - Not a forum for working on personal problems
  - Careful not to have untreated facilitators (dependents, co-dependent, adult children)
  - Be aware what "hooks" you and what pushes your buttons
  - Expect that children will try to manipulate

- BE THE FIRST TO RISK

  - Some self-disclosure is important; but don't "dump"
  - Let them know how you are feeling - they will guess anyway

- BE AN ADVOCATE FOR THE CHILD

  - Involves empathy, acceptance & genuineness
  - Don't disclose confidences (let children/parents know this up front)

- BE AWARE OF BODY LANGUAGE

  - Children will communicate more non-verbally than verbally

rulefaci

CONFIDENTIALITY IN GROUP

When we are confident in someone, we trust that person to understand what we are saying and feeling. We trust that person to respect our opinions and feelings.

It is important to remember that everybody owns his or her own feelings. That's why we have the rule "Don't tell anybody outside this group what someone else says in the group." It is not fair to tell someone else's feelings because those feelings are his or her feelings, not yours.

Also, when we are confident in someone, we trust that person to understand what we mean. It is a sad thing, but many people do not understand about alcoholism. They do not know that alcoholism is a sickness. In fact, most alcoholics themselves do not understand this. If someone were to tell an alcoholic that **they** were alcoholic, the alcoholic would probably get angry and be embarrassed. All too often, alcoholics do not believe that they are alcoholic. They don't understand alcoholism.

That is another reason why things said in the group should stay in the group. It is not a good idea to talk outside the group about another child's drinking parent. That parent might not understand about alcoholism and, if he or she heard what was said, might get really angry at the child. The child would probably feel hurt that someone in the group did not keep the confidence.

For group leaders, there is an exception to this rule. Sometimes a child is being physically or emotionally hurt by an adult. When that happens and the child tells about it here, the leader has a responsibility by law to report it to the agency in charge of protecting children. All children deserve to be protected.

In general, the rule is:
"Don't tell other people outside the group about things that someone else said in the group".

We will keep each other's confidences. We will trust each other.

IMPLEMENTING A SUPPORT GROUP
FORM

1. My goal in starting a children's support group is: _____
_____
_____

2. I intend to implement the support group in:
___ Elementary schools
___ Treatment centers
___ Mental Health centers
___ Private practice
___ Non-profit agency
___ As a volunteer for:
  ___ Religious organizations
  ___ Community service groups
  ___ Pre-Alateen groups
___ Start my own agency
___ Other

3. What are the advantages of your organization?
___ Administration or organization supports project
___ Administration or organization provides funds for the project
___ Children are present (schools)
___ Identified clients (treatment centers)
___ I can make my own decisions
___ Continuing training
___ Other: _____
_____

4. Who will fund the groups? _____
_____

Funding Options Include:
___ Grants from foundations
___ Grants from corporations and businesses
___ Client fees
___ Community service organizations
___ Treatment centers
___ Consultant fees
___ Donations
___ Volunteer services
___ In kind contributions
___ Co-sponsorships
___ Other: _____
_____

5. The strengths and knowledge I bring to this project are:
   ___ Special training
   ___ Education
   ___ Love of children
   ___ Knowledge about chemical dependency
   ___ Previous experience
   ___ Decision making power in organization
   ___ Other: _____
   _____

6. STAFFING: Who will administrate the groups? Who is responsible for what?
   Administration _____
   Fundraising _____
   Arousing community interest and support _____
   Training and coordinating support group facilitators _____
   Recruiting children _____
   Press releases to newspapers and community agencies _____

7. ACTION PLAN: When the decision has been made to start groups in an existing agency:
   Where will the groups be held (meeting space)? _____
   When will they start and end (dates)? _____
   At what time will they be held? _____
   How will the children be recruited? _____
   Who will do the recruiting? _____
   Who will facilitate groups? _____
   Who will coordinate the facilitators? _____
   In schools: Who will substitute for teachers? _____
   Plans for continuing facilitator support and training include: _____
   _____
   _____

8. Some people will be pioneers in their area. They will need to generate interest in helping young children of alcoholics and to establish their own support systems.
   People who will support my endeavor: _____
   _____
   _____

   Plans to elicit community support are: _____
   _____
   _____

   Possible co-sponsoring agencies are: _____
   _____
   _____

Possible co-funding agencies are: _____

_____

_____

Next steps: _____

_____

_____

When ready, refer back to steps 6 and 7.

9. Review goals and objectives periodically.

FACTS ABOUT CHILDREN OF ALCOHOLICS

1. An estimated 28 million Americans have at least one alcoholic parent.
2. One of three families currently reports alcohol abuse by a family member.
3. One out of every four school children comes from an alcoholic family.
4. Children of alcoholics are at the highest risk of developing alcoholism themselves or marrying someone who becomes an alcoholic.
5. More than 50% of all recovering members of Alcoholics Anonymous report growing up in a family with at least one alcoholic parent.
6. More than 30% of all children of alcoholics grow up and marry an alcoholic.
7. Children of alcoholics are frequently victims of child abuse, incest, neglect, and violence.
8. In 90% of all child abuse cases, alcohol/drugs are a significant problem.
9. A disproportionate number of children of alcoholics enter juvenile justice systems, courts, prisons, mental health facilities, and are referred to school authorities.
10. Children of alcoholics are prone to experience a range of psychological difficulties, including learning difficulties, anxiety, eating disorders, attempted and completed suicides, and compulsive achieving.
11. Children of alcoholics often adapt to the unpredictability and chaos of an alcoholic home by developing behaviors which result in low self-esteem, depressions, isolation, guilt, and difficulty maintaining satisfying relationships. These and other problems often persist throughout adulthood.
12. The problems of most children of alcoholics remain invisible because their coping behavior tends to be socially acceptable and approval seeking.
13. Not more than 10% of young children of alcoholics/addicts are currently receiving assistance.

Sources: **National Institute on Alcohol Abuse and Alcoholism**
National Association for Children of Alcoholics
National Council on Alcoholism

Opening Questions that Build Rapport

Think of a few questions they use to build rapport, show concern, and begin a dialogue with a student.

1.

2.

3.

4.

5.

6.

7.

8.

9.

wkstin1

Questions About Drug and Alcohol Exposure

Think of a few questions that help assess the amount and frequency of drug and alcohol exposure for a child or youth.

1.

2.

3.

4.

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9.

Questions About Drug and Alcohol Use

Think of a few questions that help them assess the amount and frequency of drug and alcohol use in which a student has engaged.

1.

2.

3.

4.

5.

6.

7.

8.

9.

wkstin2

Parental Involvement

Think of a few questions that help assess the degree of current parental involvement.

1.

2.

3.

4.

5.

Think of a few questions to increase parental involvement.

1.

2.

3.

4.

5.

wkstin3

Profile of the High-Risk Youth

Name:

Age:

Gender:

Why is this child considered to be High Risk:

What substance or substances is this child using?

What are the signs and symptoms the child is showing in the school setting?

What resiliency factors does this child have?

profileh

Round Robin Role Play

1. Everyone will have the opportunity to ask screening and assessment questions of the youth in the role play.

2. The trainer will divide the time available by the number in the group and each of the participants will have equal time to ask a few questions that build rapport, assess substance use, assess parental involvement, or increase parental involvement.

3. The trainer will play the role of the student and will look straight at the participant during the role play. However, when your time is over, the trainer will move on to the next participant in the circle.

roundrob

Suggested Components of Prevention/Intervention for Schools

Please put a check mark beside each component present in your school or school systems.

____ 1. Policy on Substance Use distributed to all new employees and students and reviewed in class to students by teachers. Parental signatures should be included.

_____ 2. Administrative and Staff Awareness and Training on Substance Use through in-service training and workshops.

_____3. Parent Awareness of Drug Prevention Activities (i.e., school-based parenting classes, SAP, Peer Helpers), signs and symptoms, service agencies, and drug use policy for the school.

_____ 4. K - 12 Alcohol and Drug Prevention Curriculum

_____ 5. Promotion of Alcohol and Drug-Free Student Activities

_____ 6. High-Risk Student Counseling

_____ 7. Suggest an Assessment to parents.

_____ 8. Educational and Motivational Counseling/Early Intervention for Inappropriate Behaviors and Risk Behaviors.

_____ 9. Conforntation/Intervention (School Board Intervention Team or SAP)

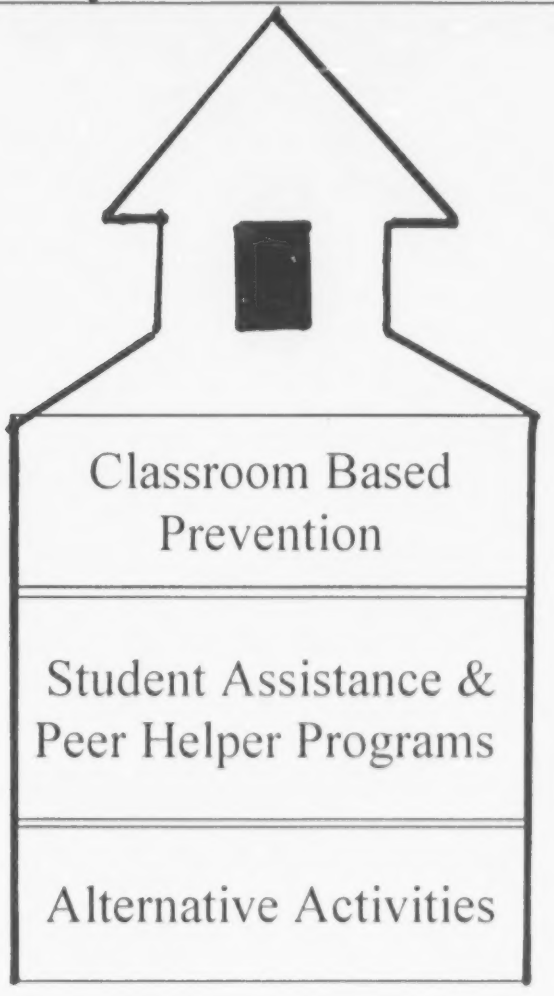
_____ 10. Awareness of Services and Agency Resources

_____ 11. Continued Contact and Coordination Between School and Service Agency when Child Leaves the System for Treatment.

_____ 12. Aftercare Support and Academic Re-entry - Provide Support for Re-entering Students.

addendum

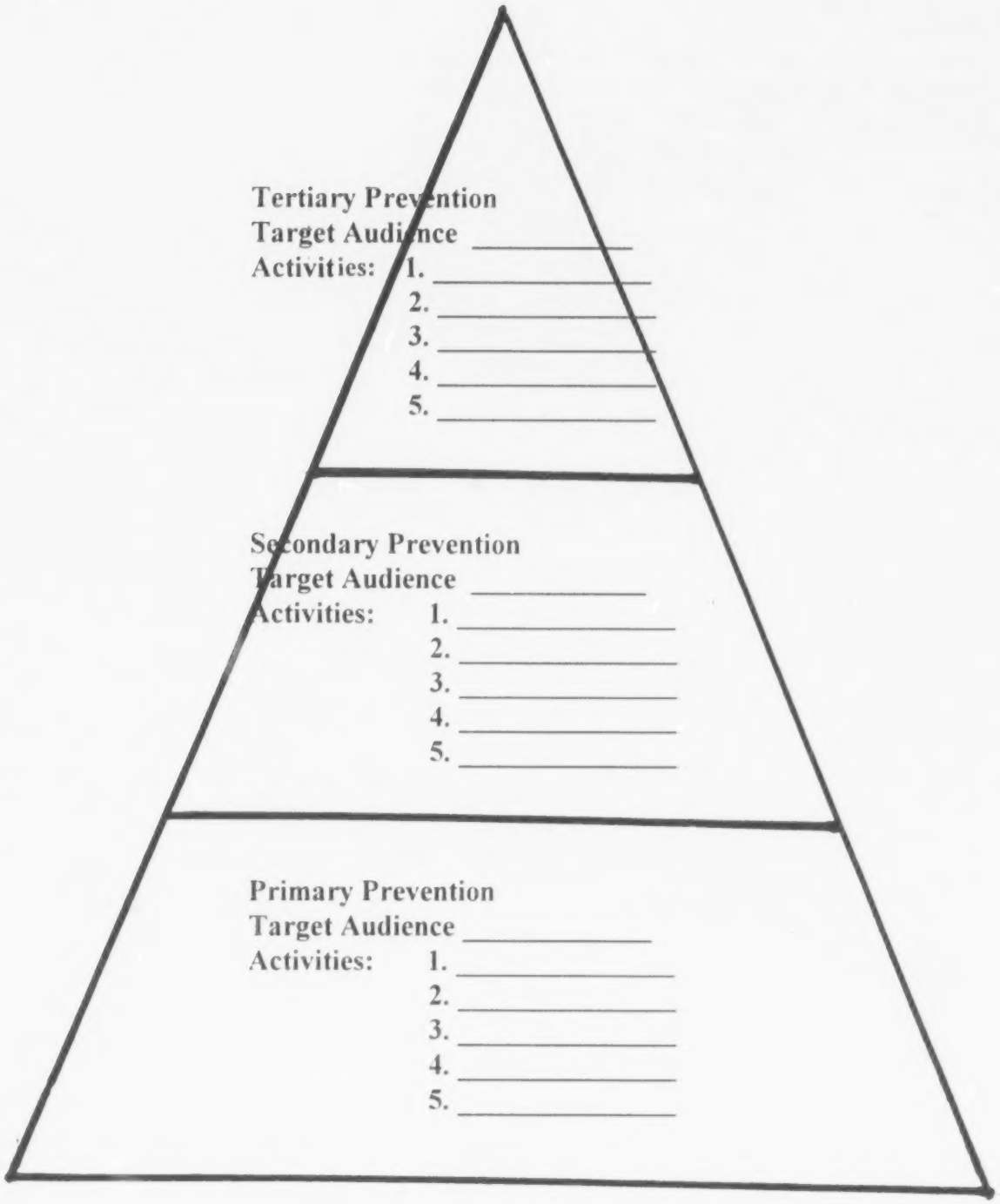
The Role of the School in the Five Major Prevention Strategies



School as a Member in the Community Prevention Network

School as a Catalyst in Public Policy Formation for Prevention

The Prevention Pyramid



In Which Area Below Are Classroom Teachers At Their Best?

Teaching Knowledge and Information ____

Teaching New Skills and New Behaviors ____

Teaching Motivations ____

addendum

SOCIAL SKILLS INOCULATION
SKILL BUILDING COMPONENTS

1. Anticipation a future event

   a. State a new behavioral goal.

   b. Clearly defining the social situation.

2. Identification of effective counter-behaviors

3. Rehearsal of these counter-behaviors

4. Peer Feedback

5. Rehearsal for skill mastery

addendum

STUDENT ASSISTANCE PROGRAMS AIMED AT SUBSTANCE USE PREVENTION AND INTERVENTION

Group Definition _____

_____

_____

_____

_____

_____

_____

addendum

STUDENT ASSISTANCE PROGRAMS

Student assistance programs focus on behavior and performance at school, using a process to screen students for alcohol, tobacco, and other drug problems. They are modeled on employee assistance programs used at many workplaces. Student assistance programs represent a partnership between community health agencies and schools, and often rely on community agencies for assessment and treatment services.

Like their industry counterparts, some student assistance programs do not limit their activities to alcohol, tobacco, and other drug problems. Instead, they focus on identifying, referring, and assisting students with all issues causing problems that hinder a student's development.

The purpose of student assistance programs is to provide school staff with a mechanism for helping youth with a range of problems that may contribute to alcohol, tobacco, and other drug use. Teachers and other school staff receive training on how to identify youths experiencing problems. However, they are not expected to intervene personally. Students are referred to appropriate assessment and assistance resources.

Elements common to most student assistance programs include: early identification of student problems; referrals to designated helpers; in-school services, such as support groups and individual counseling; referral to outside agencies; and follow-up services.

Successful student assistance programs require the commitment of school boards, principals, and community members. This level of commitment, as well as appropriate training, provides school personnel with a valuable mechanism for helping students experiencing problems.

REFERENCES

Prevention Plus II: Tools for Creating and Sustaining Drug-Free Communities (1991)
Success Stories from Drug-Free Schools (1992) PHD588

STUDENT ASSISTANCE PROGRAMS

Publications

Anderson, G. L., *When Chemicals Come to School: The Student Assistance Program Model.* Available from DePaul Training Institute, 4143 South 13th Street, Milwaukee, WI 53221, 1987.

Griffin, T., and Svenden, R. *Student Assistance Program: How It Works.* Available from Hazelden Educational Materials, Pleasant Valley Road, Box 176, Center City, MN 55012-0176, 1980.

Morehouse, E. *Preventing Alcohol Problems Through a Student Assistance program: A Manual for Implementation Based on the Westchester County, New York, Model.* Available from Student Assistance Services, 228 Fisher Avenue, White Plains, NY 10606, 1987.

Office for Substance Abuse Prevention, *The Fact Is . . . You Can Start a Student Assistance Program.* Available free from NCADI, P. O. Box 2345, Rockville, MD 20852, 1988.

Wisconsin Department of Health and Human Services. *The Student Assistance Program: The Wisconsin Experience.* Available from WDHHS, P. O. Box 7851, Madison, WI 53707, 1986.

THE FIVE BASIC STEPS IN
STUDENT ASSISTANCE PROGRAMS
AIMED AT SUBSTANCE USE PREVENTION/INTERVENTION

1. Referral to the Team

   Who refers?

   How do they refer?

2. Interview

   Who interviews the child?

   Who informs their parent?

3. Team Meeting(s)

4. In-School Intervention(s)

   What interventions are possible?

5. Outside Agency Interventions(s)

   What interventions are possible?

addendum

THE STUDENT ASSISTANCE TEAM

When developing a Student Assistance Program, who should be trained to become part of the Student Assistance Team?

1.

2.

3.

4.

5.

6.

7.

addendum

STUDENT ASSISTANCE SKILLS

When developing a Student Assistance Program, what basic skills should all team members possess?

1.

2.

3.

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7.

addendum

STUDENT ASSISTANCE PROGRAMS
TEAM BASIC SKILLS

A Student Assistance program that addresses substance use prevention and intervention should have a team training that includes:

1. Active Listening/Empathy/Communication Skills
2. Cultural Diversity
3. Confidentiality Policy
4. Clear understanding of the role and responsibilities of being a team member.
5. Referral Resources
6. Stress Management Techniques
7. Conflict Resolution and Mediation Techniques

addendum

SCHOOL BASED INTERVENTIONS

Students who are referred, or self refer, to the Student Assistance Program may receive an Intervention. What are some possible Interventions school personnel can implement?

1.

2.

3.

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addendum

WHAT ARE SOME BARRIERS TO DEVELOPING A STUDENT ASSISTANCE PROGRAM?

1.

2.

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8.

9.

addendum

WHAT ARE SOME EFFECTIVE BARRIER "BUSTERS"?

1.

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9.

addendum

PEER HELPER PROGRAMS AIMED AT SUBSTANCE USE PREVENTION AND INTERVENTION

Group Definition _____

_____

_____

_____

_____

_____

_____

addendum

PEER PROGRAMS

Research clearly and convincingly identifies the effectiveness and cost-effectiveness of even low-intensity school-based peer programs for reducing drug abusing behaviors among the general adolescent population. While peer programs come in a variety of overlapping shapes and sizes the four broad categories of positive peer influence, peer teaching, peer counseling/facilitating, and peer participation), the following discussion summarizes the characteristics that distinguish peer programs from other prevention modalities:

- Goals

  Peer programs usually espouse at least one of these goals:

  1. to generate meaningful involvement, activities, and responsibilities for youth;

  2. to channel both negative peer pressure to engage in self-destructive behaviors (substance use, sexual promiscuity, delinquency) and the "normal energies and risk-taking tendencies of youth" toward constructive ends; and

  3. to build personal and social competency skills.

- Context

  No matter "whatever the goal or particular approach of a peer program, peer programs are (ultimately) distinguished from other kinds of programs by an emphasis on young people in the context of the peer group".

- Settings

  Peer programs "tend to be located in settings where groups of young people commonly occur, either naturally and spontaneously or as a result of society's conventions and laws". Schools are the most common setting with community agencies a not too close second.

- Elements

  The critical elements of a peer program are the dynamics of peer pressure, peer influence, and group interaction.

- Adult role

The type of peer program (counseling, teaching, participation, influence) is far less important than the attitude and style of the adults involved. "In any peer program, the role of the adult program leader (ultimately) can make the difference between the program being a peer program or being simply an adult-dominated group". The attitude of the adult, then, must be one of acceptance and comfort with youth interacting freely in small informal groups and of confidence in the ability of young people to accept responsibility. The style of the adult should be facilitating and guiding -- not controlling -- and should reflect "conscious role-modeling" of appropriate group behavior -- careful listening and caring, non-judgmental statements.

PEER HELPER CHARACTERISTICS

What are the characteristics of a Peer Helper?

1.

2.

3.

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9.

addendum

SELECTION OF PEER HELPERS

Student Surveys are often used to identify potential Peer Helpers. Why is this method better than teacher/counselor/school nurse selection?

1.

2.

3.

4.

Why should there be some checks/balances in the final selection by school personnel?

1.

2.

3.

4.

addendum

PEER HELPER TRAINING

What are the basic skills and information that need to be taught to Peer Helpers?

1.

2.

3.

4.

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7.

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9.

addendum

WHAT ARE SOME BARRIERS TO DEVELOPING A PEER HELPER PROGRAM?

1.

2.

3.

4.

5.

6.

7.

8.

9.

addendum

WHAT ARE SOME EFFECTIVE BARRIER "BUSTERS"?

1.

2.

3.

4.

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9.

addendum

SCHOOL-COMMUNITY TEAMS
FOR SUBSTANCE USE PREVENTION

Community Based Prevention

Who should be included?

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Community Based Prevention

Who Should Be Included?

1. Key leaders
2. Formal community leadership
3. Elected Officials
4. Appointed Leaders
5. Agency heads
6. Ministers
7. Informal neighborhood leaders
8. Agency representatives
9. Organization representatives
10. Ethnic representatives
11. Youths
12. Elders
13. Religious organizations
14. Government agencies
15. Schools
16. Media
17. Parents
18. Businesses
19. Law Enforcement

wkstincl

School-Community Teams for Substance Use Prevention
How Does a Community Build an Effective Coalition?

1.

2.

3.

4.

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10.

Three Major Themes in Community-Based Prevention

I. Community empowerment means "doing with" the community and not "doing for" the community. This involves shifting responsibility for planning and decision making away from the agencies and professionals to the community itself.

II. Inclusion of all community groups, both formal and informal, in all prevention efforts.

III. Cultural competency, the lifelong process of incorporation, valuing, and celebrating the ethnic and cultural diversity of the community.

Source: The Future By Design: A Community Framework for Preventing Alcohol and Other Drug Problems through a Systems Approach, Center for Substance Abuse Prevention, U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, DHHS Publication No. (ADM) 91-1760, 1991.

Leadership in Community Prevention

Conventional Wisdom	Alternative
Leader has own agenda or vision.	Leader facilitates move from current state of affairs (as assessed/defined by the group) to one that is better (as envisioned by the group).
Leader establishes identity by taking stand(s) and solicits support of people for stand(s).	Leader sees a stand as a tool for engaging the people in doing work.
Mark of success is shown by carrying out stand; means of success is demonstrated by skillful interaction with people.	Leader facilitates sorting out values and points of view on complex issues.
Process involves responding to traditional idea of leader and providing solutions, security, and meaning.	Process involves mobilization of a group's resources to do work. *(Face, define, and resolve its problems.)
Repeated success of leader increases dependency on leader and weakens constituents' ability to face, define, and solve problems.	Actions serve as catalysts of work, rather than solutions to problems.

Leadership in Community Prevention

Conventional Wisdom	Alternative
Leader is successful in situations where the problem and solution (technical fix) are easily defined and available (e.g., infection - antibiotic). Leader does all the work.	When a problem is not well defined and the solution is unclear, the group (relevant community of interest) must do the work of defining and solving.
Leader accepts people's expectation (conventional wisdom) that the leader can fix things for them.	Leader goes against this expectation. Adjustments in people's attitudes are necessary.
Leadership as a position is exercised by person in authority.	Leadership is a function or activity that can be exercised at once by several people in various positions of authority.

COMMUNITY EMPOWERMENT SYSTEM: A CONTRAST IN PARADIGMS

Traditional Delivery of Services	Empowerment of Community
Professionals are responsible (doing for the community).	Responsibility is shared (doing with the community)
Power is vested in agencies	Power resides with the community.
Professionals are seen as experts	The community is the expert.
Planning and services are responsive to each agency's mission	Services and activities are planned and implemented on the basis of community needs and priorities.
Planning and service delivery are fragmented	Planning and service delivery are interdependent and integrated.
Leadership is external and based on authority, position, and title.	Leadership is from with the community, based on ability to develop a shared vision, maintain a broad base of support, and manage community problem solving.
The decision making process is closed.	Decision making is inclusive.
Accountability is to the agency.	Accountability is to the community.
Community participation is limited to providing input and feedback.	Community is maximally involved at all levels.

PHILOSOPHICAL ASSUMPTIONS FOR COMMUNITY BASED PREVENTION

The framework is based on the following philosophical assumptions:

- Prevention efforts must address the three factors defined in the public health model of prevention. Prevention efforts must be directed toward potential and active users (the host); toward the sources, supplies, and availability of the drugs (the agent); and toward the social climate that encourages, supports, reinforces, or sustains the problematic use of alcohol and other drugs (the environment).

- Prevention programs must teach 100 percent of the people. A community prevention system ideally involves, works with, and addresses all of the multiple populations, sectors, and systems within the community.

- Prevention programs and activities must be ethnically and culturally appropriate.

- An effective community prevention system demands mutual respect and equality among all groups, acknowledgement of interrelatedness, a sense of daring, and a willingness to transcend turf for positive social change. Credit for success must be shared, and the community must be seen as the expert.

- The community is the best vehicle through wnich to develop and implement comprehensive prevention efforts.

philasmp

ALTERNATIVE ACTIVITIES

The "Alternative Activity" approach to drug and Alcohol Abuse Prevention is not theory based. It simply means that youths are not involved with substance use while engaged in these activities. What are some of these Alternative Activities we frequently see in our communities?

1.

2.

3.

4.

5.

6.

7.

addendum

What are the "Pros" and "Cons" of Alternative Activities as a Substance Abuse prevention Strategy?

Pros	Cons
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.

addendum

POLICY CAN BE PREVENTION

Policy changes have been a very effective method of substance abuse prevention. What are some current laws that act as substance abuse prevention?

1.

2.

3.

4.

5.

6.

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addendum

FUTURE POLICY

Are there some potential changes in Alabama law that would further reduce Substance Abuse among youths? What suggestions do you think could be implemented?

1.

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7.

addendum

POLICY CHANGE AND SCHOOLS

How can school personnel play a role in policy change for drug and alcohol abuse prevention?

1.

2.

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5.

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7.

addendum

AGE APPROPRIATE DRUG AND ALCOHOL PREVENTION ACTIVITIES

What are some age appropriate drug and alcohol prevention activities for grades K to 3?

1.

2.

3.

4.

What are some age appropriate drug and alcohol prevention activities for grades 4 to 6?

1.

2.

3.

4.

What are some age appropriate drug and alcohol prevention activities for grades 7 to 8?

1.

2.

3.

4.

What are some age appropriate drug and alcohol prevention activities for grades 9 to 12?

1.

2.

3.

4.

TOOLS FOR PREVENTION: BUILDING HEALTHY YOUTHS

Contract Form

When I return to my school I will (what and when):

The resources (people, place, and things) I will need to do this are:

_____ _____

Name School System Name

_____

Phone Number

addendum

ACTION PLAN CHECKLIST

Look at all your options.

What would you like to change?

Is this a realistic option?

Focus on one change rather than many.

What are the barriers to implementation?

Who are your allies?

What resources will you need?

What previous experience have you had that may impact your action plan?

Can the action plan be broken down into manageable steps?

How often will you be involved in implementing the action plan?

addendum

COURSE EVALUATION

1. New skills learned?

2. Taking something home?

3. Resource discovered?

4. Activity you found useful?

5. A new piece of knowledge?

6. What did you like about this training?

7. What would you change about this training?

addendum

RESOURCE DIRECTORY

1. Alabama's School Counselors
2. Alabama's School Nurses
3. Alabama's School Psychologists
4. Drug Free Schools Coordinators
5. Substance Abuse Treatment Programs - Department of Mental Health
6. Drug and Alcohol Prevention Programs - Department of Mental Health
7. Mental Health Centers
8. Drug and Alcohol Prevention Programs - Governor's Office on Drug Abuse Policy

addendum